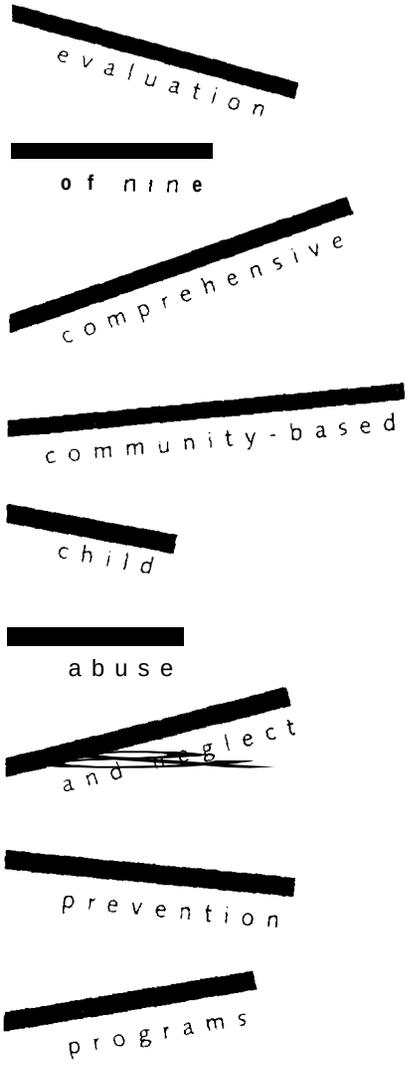
CROSS-SITE EVALUATION REPORT



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U.S. Department of Health and Human Services
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National Center on Child Abuse and Neglect
330 C Street, S.W.
Washington, DC 20201

Prepared by:

CSR, Incorporated
Suite 200
1400 Eye Street, N W.
Washington, DC 20005

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INTRODUCTION

Child abuse and neglect is a serious social problem with complex causes and tragic results. Because of the suffering and loss of life it incurs, the costs of treating the resulting physical and psychological trauma, and the linkage of child maltreatment to other social problems, such as substance abuse and criminal activity, a wide variety of efforts to prevent child abuse and neglect have been undertaken.

The National Center on Child Abuse and Neglect (NCCAN), established in 1974 by the Child Abuse Prevention and Treatment Act, has funded and supported many prevention efforts through its research, demonstration, service, and clearinghouse programs. In 1989 NCCAN began providing support for planning and developing nine model comprehensive community-based projects to encourage community groups to work together to prevent physical child abuse and neglect. NCCAN underscored its intent to have the projects be both community based and comprehensive and to network with and encourage the involvement of many community service providers. The following lists the nine projects, their grantee agencies, and their locations:

- Dorchester CARES, Massachusetts Committee for Children and Youth, Inc., Boston, Massachusetts;
- PARE (Physical Abuse and Neglect Reduction Effort), ESCAPE (Exchange Club Center for the Prevention of Child Abuse), Carolina, Puerto Rico;
- NLFSI (North Lawndale Family Support Initiative), National Committee to Prevent Child Abuse, Chicago, Illinois;
- I CARE, Crittenton Family Services, Columbus, Ohio;
- Families First in Fairfax, Fairfax County Department of Human Development. Fairfax, Virginia;
- Community Lifelines Program, Cornell University Family Life Development Center. Ithaca, New York;
- CCAPP (Community Coalition Acting for Positive Parenting), Temple University Center for Social Policy and Community Development. Philadelphia, Pennsylvania;
- Family Care Connection, Children's Hospital of Pittsburgh, Pittsburgh, Pennsylvania; and
- Project Maine Families, Cumberland County Child Abuse and Neglect Council. Portland, Maine.

CSR, Incorporated, conducted an evaluation of the nine prevention projects to examine and document their experiences and contribute to an understanding of ways to mediate risk factors and strengthen families through solid partnerships with their communities. This report presents a cross-site analysis of the experiences of the nine grantees, incorporating data collected by both CSR and the projects, and makes policy recommendations derived from CSR's findings.[1]

This chapter provides a context for understanding the experiences of the nine projects. Literature documenting the child abuse and neglect problem in the United States is reviewed, and the history of prevention programs and findings regarding their effectiveness are summarized, Chapter 2, Study Findings, details the study methodology, the project models, and the projects' implementation experience as well as presents the evaluation findings, including individual and community outcome results. Chapter 3, Conclusions,

[1] For details regarding the individual projects, refer to the case studies written as part of the cross-site evaluation (CSR, 1996a–i). A separate report on the projects highlights their experiences and describes policy recommendations derived from the experiences (CSR, 1996j).

summarizes the important lessons learned by the projects and offers policy recommendations based on these lessons.

EXTENT OF THE PROBLEM

Public attention in the United States focused sharply on the child abuse problem during the 1960s, when physician Henry Kempe and his colleagues introduced the battered child syndrome as a medical diagnosis (Kempe, 1962). Between 1963 and 1967, child abuse reporting laws were enacted in all 50 States and the District of Columbia. The reporting laws led to increased documentation of child abuse and neglect cases and more Federal involvement in the prevention of and remedies for child maltreatment.

Federal efforts to protect children and prevent child maltreatment have centered on the following four laws enacted between 1974 and the mid-1980s: (1) Title XX of the Social Security Act, (2) the Child Abuse Prevention and Treatment Act, (3) the Adoption Assistance and Child Welfare Act, and (4) the Family Preservation and Family Support Act. These four Acts established funding for social services related to child abuse and neglect prevention and treatment, created discretionary and State grants for demonstration and service programs, and provided funding and direction for States and counties so they could focus on reducing core family problems leading to child abuse and neglect.

Child maltreatment continues to be a major problem in the United States. A review of the research on its human, social, and fiscal costs reveals that large numbers of children are victimized, and their suffering often is both immediate and lifelong (Meyers and Bernier, 1987). Although accurate reporting is made difficult by wide variations in State data collection procedures, available statistics indicate that the incidence of child maltreatment is increasing.

Incidence of Child Maltreatment

According to the third National Incidence Study of Child Abuse and Neglect (NIS-3), the number of abused and neglected children doubled between 1986 and 1993, from 1.4 million to more than 2.8 million (Sedlak and Broadhurst, 1996). The study estimated that the number of children who were seriously injured during that period quadrupled from approximately 143,000 to nearly 570,000.

The researchers state that these increases in child abuse and neglect probably are due to increased awareness and recognition, as well as real increases in the scope of the problem (Sedlak and Broadhurst, 1996). The magnitude of the increase in the number of seriously injured children indicates a true rise in the scope and severity of child abuse and neglect in the United States. However, a rise in the number of children endangered but not yet harmed by maltreatment[2] points to improved recognition of more subtle cues that indicate abusive and neglectful behaviors that have not yet resulted in harm or injury.

This finding parallels that of the National Committee to Prevent Child Abuse's (NCPCA's) *1995 Annual Fifty State Survey* (Lung and Daro, 1996), which also attributed the increase in the nationwide rate of child abuse and neglect reports to both increased awareness and more accurate assessment of the problem. The NCPCA survey asked State liaisons to name the two factors having the most influence on reporting trends in their State. Eleven (69 percent) of the responding

[2] The NIS-3 used two types of definitional standards---the Harm Standard and the Endangerment Standard. The Harm Standard was relatively stringent, requiring that an act or omission result in demonstrable harm to be classified as abuse or neglect. The Endangerment Standard included all children who met the Harm Standard as well as other children who were not yet harmed by maltreatment but were considered to be endangered or whose maltreatment was substantiated or indicated in a child protective services investigation.

liaisons attributed the rise in the number of reports to increased public awareness resulting from more attention from the media. Procedural changes, such as improved data collection methods (e.g., telephone surveys) and better reporting, was the next most common response, made by seven (44 percent) of the responding State liaisons. Six State liaisons reported that substance abuse and violence had impacted child abuse and neglect in their States and had contributed to the increase in reporting (Lung and Daro, 1996).

The NIS-3 found that only a minority of the children who were abused 'or neglected received attention from child protective services (CPS). The percentage of children who received CPS investigation decreased significantly during the period 1986 to 1993, from 44 percent to 28 percent of children under the Harm Standard (Sedlak and Broadhurst, 1996). At the same time, the *number* of children under the Harm Standard investigated by CPS remained constant, indicating that a larger percentage of them did not receive CPS investigations of their maltreatment. The researchers suggest that this finding indicates that the CPS system has reached its capacity to respond to reports of maltreated children. This interpretation strongly points to the need for continued emphasis on prevention initiatives similar to the nine projects that are the focus of this report.

Types of Child Maltreatment

Child neglect is the most commonly reported and substantiated form of maltreatment of children in the United States. Neglected children often die because they are left unattended during house fires, lack medical treatment, or are left alone with insufficient food or water. One researcher found that approximately 65 percent of child abuse and neglect reports were for neglect (DiLeonardi, 1993).

The NIS-3 study found that the number of physically neglected children under the Harm Standard increased from 167,800 in 1986 to 338,900 in 1993-a 102-percent rise in inctdence-while the number of emotionally neglected children increased from 39,200 to 2 12,800, a 333-percent increase (Sedlak and Broadhurst. 1996). The researchers noted that neglect warrants more attention because it affect\ the greatest number of maltreated children. and their injuries often are serious.

The study also estimated that the number of physically abused children under the Harm Standard increased 42 percent, while the estimated number under the Endangerment Standard (a more inclusive standard) increased 97 percent; the researchers suggested that this trend implies an improvement in professionals' recognition of subtle cues associated with children experiencing not-yet-injurious abusive actions (Sedlak and Broadhurst. **1996).**

The number of sexually abused children under the Harm Standard increased 83 percent during the time period, from 119,200 to 217,700. while the number of sexually abused children under the Endangerment Standard increased 125 percent, from 133,600 to 300,200 (Sedlak and Broadhurst. 1996). Under both the Harm Standard and the Endangerment Standard, the study found that girls were sexually abused about three times more often than boys. The NCPCA study, which estimated that 109,230 sexual abuse cases were accepted for service in 1995, pointed out that this incidence is much higher than the number of cases-10.000 to 20,000—typically accepted for service in the 1970s and early 1980s (Lung and Daro, 1996).

Child Maltreatment Fatalities

It is sobering to realize that an estimated 2,000 infants and young children die annually from abuse or neglect (Advisory Board on Child Abuse and Neglect, 1995). In the United States. physical abuse is the leading cause of death among children less than 1 year old. Lung and Daro (1996) found that more than three children died every day in 1995 as a result of parental maltreatment, the same number that NCPCA **surveys** have supported for the past 10 years. Between 1993 and 1995. 37 percent of child maltreatment fatalities resulted

from neglect, 48 percent resulted from abuse, and 1 5 percent resulted from both forms of maltreatment.

The rate of child maltreatment fatalities has risen steadily for IO years. from 1.30 to I .8 I per 1,000 between 1985 and 1995, which is a 39-percent increase. It is estimated that between 1992 and 1995, the overall death rate rose by 5 percent. According to reports from 34 States, an estimated 1,315 children died from abuse or neglect in 1995 (Lung and Daro, 1996).

Young children remain at particularly high risk. NCPCA, using data from 1993 through 1995, found that 85 percent of child fatalities involved children younger than age 5, while fully 45 percent involved children younger than age: 1. Research at the Centers for Disease Control and Prevention suggests that abuse and neglect kills 5.4 out of every I 00,000 children age 4 and younger (McClain, Sacks, and Frohlke, 1993). However, because children's deaths often are misclassified, McClain believes that a less conservative estimate could be as high as 11.6 per 100,000 (McClain et al., 1993).

Data from other studies strongly suggest that these number-::, undercount the actual number of maltreatment fatalities in the United States. Many cases classified as accidental death, c hild homicide, or sudden infant death syndrome might more appropriately be labeled child maltreatment deaths, if more comprehensive investigations were conducted (Lung and Daro. 1996).

Costs of Child Maltreatment

The human, social, and fiscal costs to society are difficult to estimate. These include lost human life, crimina l detentions, institutionalization, special education, and emergency and therapeutic services. Year-fatal child abuse and neglect leaves 18,000 American children permanently disabled each year (Advisory Board on Child Abuse and Neglect, 1995). Tens of thousands of victims suffer psychological trauma that may scar them fog. life, and siblings and other family member., are traumatized by the victim's maltreatment Further-more. in many families, child maltreatment becomes a pattern that is repeated in each new generation.

In addition, child maltreatment underlies or is associated with many ma jor social problems Retrospective studies doc ument the prevalence of childhood abuse and neglect in the most disabled and dysfunctional membe rs of society. The following statistic:; illustr ate to what extent child abuse and neglect Impact various troubled or at-risk groups (Meyers and Bernier, 1987):

- 22 percent of children institutionalized for mental retardation;
- 23 percent of children handicapped by cerebral palsy;
- 30 to 40 percent of children hospitalized for psychiatric disturbance:,;
- 75 percent of adults dia gnosed for multiple personality disorders;
- more than 80 percent o juvenile delinquents;
- '7 I to 92 percent of adolescent runaways;
- 45 to 57 percent of chil I molesters; and
- 45 to 65 percent of adolescent and adult prostitutes were victims of child maltreatment

Linkage Between Child Maltreatment and Other Conditions

The causes of child maltreatment in the United States are complex. Important contributing factors include family structure and size, poverty, alcohol and substance abuse, domestic violence, and community violence.

Family Structure and Size.- -The NIS-3 study found that children of single parents were at higher risk of physical abuse and o all types of neglect. and children living with only their fathers were

approximately one and two-thirds times more likely to be physically abused than those living with only their mothers (Sedlak and Broadhurst, 1996). The study also found that children in the largest families were physically neglected at nearly three times the rate of those who came from one-child families. The researchers pointed out that the added responsibilities and stresses associated with single-parenting and with numerous children in a household probably at least partially explain the relationship between the incidence of maltreatment and family structure and size (Sedlak and Broadhurst, 1996).

Poverty.-Although the literature on child maltreatment suggests that most poor parents do not abuse their children, there does appear to be a link between poverty and child maltreatment. It also is clear that some social and demographic characteristics do increase the likelihood that poverty will lead to abuse or at least to the reporting of abuse. The NIS-3 study found that family income was significantly related to incidence rates in nearly every category of maltreatment; children in families with annual incomes below $15,000 were more than 22 times more likely to experience maltreatment, more than 44 times more likely to be neglected, and more than 22 times more likely to be seriously injured by maltreatment under the Harm Standard than children in families with incomes of $30,000 or more (Sedlak and Broadhurst, 1996).

Some researchers have found that the label of child abuse and neglect is more likely to be applied to poor families, while families with greater resources are more likely to escape public notice. For example, Newberger, Reed, Daviel, Hyde, and Kotelchuck (1977) suggest that poor and minority children have a preferential susceptibility for receiving "child abuse and neglect" diagnoses. The NIS-3 researchers noted that their findings were not likely to be explained based on a higher visibility of lower income families to community professionals; the majority of maltreated children were reported by schools, and children attending schools represent a broad spectrum of family income levels. They also pointed out that a number of problems associated with poverty may contribute to a higher child maltreatment rate. including more transiency in residence. poorer education, higher rates of substance abuse and emotional disorders, and less adequate social support systems (Sedlak and Broadhurst. 1996). They added that decreased economic resources among poor families and the increase in the number of children living in poverty may at least partially explain the increase in incidence rate since 1986.

Findings from the NCPCA survey support the conclusions of the NIS-3. In that survey, 18 State liaisons (49 percent) stated that after substance abuse, poverty and economic stress was the nest most frequently cited problem area for families on CPS caseloads (Lung and Daro, 1996). Poor housing and limited community resources were common factors among families reported and substantiated for child maltreatment.

Alcohol and Substance Abuse.-Alcohol is the most commonly abused substance in the United States. Evidence shows that alcohol is related to violence in general and to family violence in particular. Research on homicide, assault, child abuse, and spouse abuse indicates substantial associations between alcohol abuse and violence (Gelles, 1992).

The NIS-3 researchers were struck by how often illicit drug use was noted in the narrative descriptions on the NIS data forms, and they pointed out that the increase in illicit drug use since 1986 may have contributed to the rise in incidence observed in 1993 (Sedlak and Broadhurst, 1996). The NCPCA survey (Lung and Daro, 1996) found that of 37 State liaisons who responded, 81 percent (30) named substance abuse as one of the top two problems exhibited by families reported for maltreatment, an increase from 76 percent in 1994 and 63 percent in 1993

Children of drug-addicted parents are at extremely high risk for maltreatment from infancy through adolescence because of the physiological, psychological, and sociological nature of addiction

The NCPCA survey (Lung and Daro, 1996) estimated that 10 million children in the United States are being raised by addicted or alcoholic parents and that at least 675,000 children are seriously maltreated each year by an alcoholic or drug-abusing caretaker.

According to the President's 1990 *National Drug Control Strategy* Report, as many as 100,000 cocaine-exposed babies are born annually (Cook, Peterson, and Moore, 1990). Another estimate indicates that at least 11 percent of pregnant women nationwide are using illegal drugs (Lung and Daro, 1996) A 1991 study conducted for the Advisory Board on Child Abuse and Neglect concluded that services for substance-abusing parents were inadequate in most parts of the Nation, (Advisory Hoard on Child Abuse and Neglect, 1991).

Domestic Violence.—Some experts believe that there is a clear link between assaults on women and child abuse, with domestic violence as the single major precursor to child abuse and neglect fatalities in the United States (Advisory Board on Child Abuse and Neglect, 1995). Domestic violence has ominous implications for infant development (Osofsky and Fenichell, 1994). There have been several reported cases of young children (ages 2 to 4) having witnessed parent-parent homicide, which is considered a catastrophic psychological trauma for a young child (Schetky, 1978; Zeanah and Burk, 1984).

Estimates vary of the number of abused children living in homes in which their mothers also are being physically abused. For example, in the NCPCA survey (Lung and Daro, 1996), seven State liaisons (19 percent) reported that a significant percentage of their adult clients experienced domestic violence and had their own history of battering. Child protection workers in the Massachusetts Department of Social Services also reported that an average of 32.5 percent of their cases statewide involved domestic violence (Hangen, 1994). A survey conducted by Straus and Gelles (1990) found that SO percent of the men who frequently assaulted their wives also frequently physically abused their children. This study also found that mothers who were beaten were at least twice as likely to physically abuse their own children as mothers who were not abused.

Community Violence.—Community violence has reached epidemic proportions in urban areas of the United States (Osofsky and Fenichel, 19'91). According to Garbarino. Kostelny, and Dubrow (1991) and Osofsky and Fenichel (1994), many children living in major U.S. cities experience conditions similar to a war zone, and many children living in inner cities report that they do not expect to live beyond their teenage years. A recent survey at Boston City Hospital found that one of every 10 children younger than age 6 attending the Pediatric Clinic had witnessed a shooting or stabbing. Half of these incidents occurred in the home, and the other half took place outside the home or in the street (Osofsky and Fenichel, 1994). A survey conducted by Chicago's Community Mental Health Council found that nearly 40 percent of 1,000 Chicago high school and elementary school students had witnessed a shooting; more than 33 percent, a stabbing; and 25 percent. a murder (Garbarino et al., 1991).

Although young children usually are not participants in criminal activity, their presence in a violent environment increases their risk of being physically and psychologically harmed. Homicide accounts for 10 percent of all deaths of children ages 1 to 4 (Osofsky and F'enichel, 1994). According to the American Humane Association (1996), 13 children are killed and 30 'children are wounded by guns every day in the United States. Since 1988 American teenage boys have been more likely to die from gunshot wounds than from all other causes combined. According to the Children's Defense Fund (1996), firearm violence---whether homicide, suicide, or accidental shooting--killed 5,367 children (ages 1 to 19) in 1992.

CHILD ABUSE AND NEGLECT PREVENTION

Helfer (1982), applying the medical mode1 of prevention to child maltreatment. makes a distinction between primary, secondary, and tertiary levels of prevention. These levels are closely interrelated, and the distinctions between them depend on when the target population is identified and how soon preventive actions are undertaken.

Primary, Secondary, and Tertiary Prewntion Programs

Primary prevention involves services aimed either at individuals (e.g., all residents of a community) or at a defined subset of individuals (e.g., all parents of infants) to ensure that abuse never occurs. The individuals in these target populations have not been identified as being at particular risk for child abuse and neglect; rather, the prevention services are provided to all persons in the group. Prevention programs often provide information and education to the population in general and promote family relationships and community involvement. Points of contact between families and organizations, such as hospitals, schools, churches, and community agencies, are ideal settings for outreach programs that routinely serve all parents and families that use them (Vondra, 1993).

The following components for the nine community-based projects, as described by NCCAN in the grant announcement, were primary prevention activities:

- Public awareness programs for citizens about positive parenting and positive family support;
- Prenatal health care and parenting education and support programs for all new parents; and
- School-based, age-specific prevention education programs for all school-age children.

Secondary prevention involves those services targeted at an individual or group of individuals who have been identified as being at high risk for child abuse and neglect; the purpose is to ensure that children are not abused. Activities at this level of prevention are directed at specific populations, such as single mothers, teenage parents, youth, or low-income families, and typically offer education, treatment, and support

The following components, as described in the grant announcement, were secondary prevention activities:

- Support services for parents under stress that encourage parent participation:
- Coordination between child abuse and neglect services and domestic violence programs;
- Projects for the prevention of alcohol and drug-related child abuse; and
- Hospital-based information and referral service\ for parents of children with handicaps.

Tertiary prevention involves services initiated after maltreatment has occurred to prevent the recurrence of abuse or neglect. Education. support. and treatment are provided to victims of abuse or those who have maltreated their children. These efforts typically are the responsibility of local CPS agencies.

The following components, as described in the grant announcement, were tertiary prevention activities:

- Therapeutic care for victims and perpetrators of abuse and home-based transition and followup services for children and their families; and
- Hospital-based information and referral services for children who have been neglected or abused by their parents.

Effectiveness of Child Maltreatment Prevention Programs

A number of studies have found positive short-term outcomes and evidence of effectiveness for child abuse prevention programs. Some types of

programs, such as multilevel programs that offer additional services over a longer period of rime, home visitation programs. and early parenting education programs are more likely to be successful. However, gaps in the quality of evaluations of child abuse prevention programs make it difficult to document program success and prove program effectiveness.

Primary and Secondary Prevention Interventions.—Reviews of methodologically rigorous secondary prevention studies indicate generally positive' findings (U S. General Accounting Office [GAO], 1992; Advisory Board on Child Abuse and Neglect. 1993a) Family support studies (some of which vary in their definitions of at-risk parents) have found short-term positive outcomes, particularly for parents and for those mothers (deemed at greatest risk (e.g., those who are single and poor). Secondary prevention efforts have resulted in positive gains in parental behavior, as indicated by indirect measures of their knowledge and attitudes. Several studies also have found improvements in observed parental behavior and, to a lesser extent, in indicators of child maltreatment (e.g., child abuse reports). Preliminary yet persuasive evidence suggests that multilevel programs (e.g., those offering additional services over a longer period of time) for higher risk families are worth the additional effort and expense compared with less intensive services (Advisory Board cm Child Abuse and Neglect, 1 993aj.

Home visitation programs also have demonstrated empirical effectiveness (Rosenberg and Reppucci, 1985; Gray and Halpern, 1989; Olds, 1983; Olds and Henderson, 1989). Programs for families with children ages 1 to 3 that provide a personalized approach stand out as most successful in achieving the desired 'outcomes, especially with higher risk individuals. One project implemented in the early 1980s, the Elmira Prenatal/Early Infancy Project, served poor, unmarried teenage mother:; recruited from prenatal clinics. Families in this project who received nurse home visits had an abuse rate 50 percent lower than those who did not receive such services. Among unmarried, low- income, teenage mothers who received these services until their children were 2 years old. the abuse rate was nearly 80 percent lower han among those in similar high-risk groups who did not receive services (Olds, 1983). In addition, these mothers experienced an 82-percent increase in the number of months; they were employed and a 43-percent reduction in subsequent pregnancies within the first 4 years after the birth of heir first child. However Olds (1'983) points out that for mothers who were more specifically at risk of maltreatment because of traumatic childhoods, comprehensive therapy and broader, neighborhoodwade changes were needed in addition to the support services provided by the nurse home visitor.

Gray and Halpern's (1989) meta-analysis of primary and secondary early parenting intervention programs noted that the earlier parenting education programs are offered to parents or potential parents, the: more effective they are; however, whether these effects are long lasting has not been tested. Programs with self'-selected or voluntary clients were shown to be more effective than programs with compulsory participation, and programs that sought to encourage or change particular parental behaviors appeared to be more effective than programs targeting attitudes or perceptions. For programs aiming to change parenting attitudes, the more specific the program was in targeting participants, the more effective it was.

Less rigorous evaluations of both primary and secondary programs, attempted to assess the programs short-term effects. Of the 18 programs whose short-term effects were assessed, 13 were reported to have achieved positive benefits, such as improved parenting skills, increased parental self-esteem and knowledge of child development, and reduced numbers of abuse reports (GAO, 1992).

Cost-benefit studies suggest that although prevention can be costly. it pays for itself in the long run. For example, the Michigan Children's Trust Fund study showed that providing a year-long parent education and home visitor program to every Michigan family with a new, firstborn baby

would cost approximately $43 million per year (GAO, 1992). By contrast, the estimated total State cost of dealing with the results of abuse and low-birthweight babies exceeds $823 million annually.

A review of the literature reveals that large gaps exist in the quality of child abuse prevention evaluations. Fink and McCloskey (1990) identified the following shortcomings: inadequate definition of child abuse and neglect; paucity of valid measurements; lack of specification of the characteristics of families who benefit the most from programs; and omission of important topics. such as consequences and costs of medical neglect and cost-benefit analysis. Indirect (e.g., parenting attitudes and behavior) as well as direct (e.g., agency reports) measures of child abuse prevention need to be examined (Advisory Board on Child Abuse and Neglect, 1993a). In addition, there is a lack of studies pertaining to the broader neighborhood and community contexts of child maltreatment; the importance of culture; the relationships between social isolation, social support, and child maltreatment; and the child or family characteristics that predict the efficacy of alternative interventions (Thompson and Wilcox, 1995).

Tertiary Prevention Interventions.—One review of child- and parent-focused treatment interventions that used rigorous methodologies found that child-focused programs for preschool children showed some evidence of usefulness (Wolfe, 1993). Participants showed improvement in social behavior, cognitive development, self-concept, and reduction in aggressive and coercive behaviors, but there was a lack of information on how well these programs met the needs of parents or improved family functioning.

The same review found that in parent-focused treatment, cognitive-behavioral interventions demonstrated a relatively greater degree of effectiveness in modifying parental characteristics that are most relevant to child maltreatment (e.g., parenting skills, perceptions, and expectations of children). Several studies using randomly assigned control groups also have shown reduced recidivism of maltreatment rather than just changes in specific attitudes or behaviors. However, cognitive–behavioral intervention programs were limited because they were not effective for those who had long-standing or psychiatric disorders, nor were they useful in improving families' socioeconomic conditions.

A review of all Federal child abuse treatment evaluations (Daro, 1988) and studies of maltreatment intervention programs relative to comparison groups (Berkeley Planning Associates, 1977; Cohn, 1979; Pecora, Whittaker, and Maluccio, 1992) found that maltreatment intervention programs generally have failed to demonstrate stable, long-term improvement in parent-child relations and child welfare outcomes.

However, program interventions that do produce changes have three common factors—multifaceted services, home visits, and active social support systems (Vondra, 1993). After reviewing studies of comprehensive multiservice treatment program. Wolfe (1993) similarly concluded, on the basis of positive preliminary findings, that interventions initiated during crisis situations may have more impact due to the family's heightened motivation to change. It also was found that a detailed contract between clients and therapists may permit more accurate and complete assessment and may facilitate maximum responsiveness of the treatment program to the needs of the families.

CONCLUSION

Despite a wide variety of prevention efforts, child maltreatment remains a serious problem. The available data show that the incidence of child abuse and neglect appears to be increasing and often is connected to other social problems such as domestic and community violence, substance abuse, and poverty. Prevention programs must take into account the communities in which their target populations live and the stresses and dangers they face.

The nine child abuse prevention projects discussed in this report built on research findings, some of which were summarized above, and experimented with new services and approaches to develop comprehensive responses to local needs. Each of the projects incorporated NCCAN's recognition of the need to develop longer term, multifaceted projects that encourage networking and promote involvement of many community service providers. In addition to the basic framework established by NCCAN—that the projects were to be comprehensive and community based—the approach taken by each project was shaped by the geographic, ethnic, demographic, and economic context of each community. The projects also reflected the phrlosophy of their own architects, their history in the community, and the requirements of other sources of funding

This grant program provided NCCAN and the prevention field a singular opportunity to learn about the strategies that work best to bring together community resources to prevent child maltreatment. The findings of the cross-site evaluation presented in this report. are intended to contribute to the effectiveness of prevention programs by highlighting how these nine communities established comprehensive projects for strengthening families and preventing child maltreatment and by providing an understanding of what worked in those communities and why. The findings are presented in the next (chapter

STUDY FINDINGS

In September 1992, the National Center on Child Abuse and Neglect (NCCAN) awarded a 3-year contract[3] to CSR, Incorporated, to conduct an evaluation of the nine comprehensive community-based child abuse and neglect prevention projects. The evaluation's primary research objectives were to (1) design and implement a process evaluation of the nine projects, (2) provide technical assistance to the projects in meeting the requirements of a third-party evaluation, and (3) aid the projects in their efforts to design and implement their own internal project evaluations. This chapter presents the findings of the evaluation.

METHODOLOGY

CSR's evaluation included three broad strategies. The first involved an extensive project record review whereby CSR staff would collect, review, and analyze documents regarding development and performance of the projects. CSR used documents such as grant applications; progress reports; evaluation reports; and various other types of materials (e.g., manuals, logs, and newspaper clippings) supplied by the projects.

The second strategy involved collection of field data through site visits. CSR staff conducted up to four 3-day site visits per year to each project to collect information on the purposes and interventions of the projects, the larger community contexts, the clients served, project operations, and the projects' internal evaluations. Data were collected through onsite discussions with staff, clients, and community members; observations of project activities; focus group discussions with project participants; and record reviews.

The third strategy involved analysis of both quantitative outcome data from the projects' evaluations and qualitative (i.e., descriptive) implementation and outcome information collected onsite. At the beginning of the study, CSR requested client-level data from the projects for statistical analysis to determine if there were any significant changes in indicators pertaining to child maltreatment. Furthermore, as described below, CSR provided extensive technical assistance to projects on collecting those data. However, most projects encountered numerous problems in their outcome evaluations (discussed in detail later in this chapter), and few projects employed rigorous evaluation designs, measured outcomes with valid and reliable instruments, or prepared data for client-level analysis. Therefore, the quantitative analysis of project outcome data was eliminated, and CSR's evaluation concentrated on the qualitative implementation and outcome information available from the projects and from CSR's data collection activities.

The lack of client-level quantitative outcome data made it difficult to reach conclusions regarding program participants and whether any change\ reported or observed can reasonably be attributed to a project. However, the projects did provide often-compelling narrative and anecdotal evidence attesting to their positive effects in the communities. This is important because NCCAN's intent in funding these projects was to empower and mobilize community resources and strengthen communities' focus on the prevention of child abuse and neglect.[4] The emphasis was less on

[3] The original 3-year contract eventually was extended to a fourth year. This enabled CSR to track changes in the target communities well beyond the end of the projects' NCCAN funding, a crucial feature in an evaluation assessing community impacts.

[4] The *Federal Register* (1989, p. 23570) stated, "There is the need. therefore. to once again focus on and support comprehensive community-based approaches to the prevention of child abuse and neglect....NCCAN is interested in providing support for the planning and development of model comprehensive community-based physical child abuse and neglect prevention programs to address local needs...."

changes in the number of child maltreatment reports and more on changes in the communities to increase their commitment to strengthening families and preventing child maltreatment. In fact, child maltreatment reports might escalate as community awareness of the problem increases, although the actual incidence of child maltreatment might decrease. Similarly, parents' scores on measures of childrearing behaviors might appear to indicate an increase in their propensity to abuse their children, when actually they became more aware of their child management and disciplinary behavior through participation in a project's parenting classes, without an actual increase in any abusive behavior. Thus, this report relies on the qualitative data to recount the nine projects' most significant experiences in implementing comprehensive, community-based interventions and to report the important findings based on their experiences.

NCCAN's second and third research objectives involved providing technical assistance to the nine projects to (1) aid their participation in the CSR evaluation and (2) contribute to the design and implementation of their own evaluations. Early in the evaluation (December 1992), CSR conducted a conference for the nine projects to provide them with in-depth technical assistance on conducting their own evaluations. The CSR site visits described above also were used to provide technical assistance to the projects, and technical assistance was provided through frequent telephone conversations between CSR technical staff and project staff. In addition, two CSR consultants provided specialized technical assistance in program evaluation through telephone calls and site visits. Examples of technical assistance topics include choosing relevant outcome assessment measures, developing comparison groups, selecting samples, and analyzing data. Appendix A contains a sample memorandum on outcome assessment measures that was sent to the projects.

Finally, CSR's evaluation design was reviewed and approved by a Technical Advisory Panel, whose members included the following experts:

- Dorothy Browne, D.P.H.
  School of Public Health
  University of North Carolina
- Judith Coulter
  Center for Substance Abuse Prevention
  Substance Abuse and Mental Health Services Administration
- Patrick Curtis, Ph.D.
  Director of Research
  Child Welfare League of America
- Carl Dunst, Ph.D.
  Early Childhood Intervention Project
  University of Pittsburgh
- Karen C. Mitchell
  Head Start Bureau
  Administration for Children and Families
- Peter Muehrer, Ph.D.
  Chief, Youth Mental Health Program
  Prevention Research Branch
  National Institute of Mental Health
- Gloria Johnson-Powell, M.D.
  Director, Camille Cosby Center
  Judge Baker Children's Center
- Gerald Silverman
  Office of Assistant Secretary for Planning and Evaluation
  U.S. Department of Health and Human Service\

ASSESSMENT OF PROJECT IMPLEMENTATION

The nine funded projects began a 5-year demonstration period in September 1989.[5]

[5] The 5-year period was viewed by all nine projects as a critical factor in the success of the demonstration. Shorter demonstration periods often do not provide sufficient time to modify program design and operation as needed to learn from and respond to real-life circumstances in the target communities.

Although they all focused on the same NCCAN requirements, no two projects implemented precisely the same components, and those implementing the same general components implemented them in very different ways, as discussed later. Project implementation experiences varied greatly. Several projects had slow and prolonged startups when the staff and advisory councils found it difficult to determine a specific course of action or the activities that would engage the target communities in effective prevention efforts. Other projects reported that they "hit the ground running" and were able to provide some services to the target population within a few months of the start of NCCAN funding. Some projects moved into action soon after NCCAN support was first received but then significantly changed course after the first year or two.

Grantee Agencies

The projects were implemented by a variety of grantee agencies, including universities, child abuse prevention organizations, a hospital, and a county agency. Even when implemented by similar types of grantee agencies, projects' activities, characteristics, and experiences were greatly diverse. For example, three projects operated under the guidance of existing community child abuse prevention task forces. Nevertheless, their project experiences, the approaches they used to work with their communities, and the extent to which they were institutionalized following the completion of NCCAN funding varied greatly. Two projects were initiated by single agencies as expansions of the agencies' original programs. These projects varied in their approaches, their interest in and ability to engage participation and volunteers, and the extent to which they were institutionalized. Three projects shared the benefits and obstacles of operating under the auspices of large bureaucratic institutions; each varied greatly in the time it took to get strategies in place. their approaches, and their ability to develop effective collaboration and institutionalize programs and prevention strategies. Finally, one project was implemented by a collaborative relationship specifically developed for the demonstration project. .

Target Communities

By design. the projects' community contexts varied considerably and included rural, suburban, and urban settings. Five of the nine demonstration projects targeted their interventions toward multiple communities, while the remaining four project\ each worked within a single, defined location. For example, one project targeted two separate and distinct counties in the State, one rural and the other urban; another project operated offices in three separate cities; and a third project targeted both a rural community and a small town. One suburban project developed project activities and resources in three distinct ethnic neighborhoods within a single county, and another targeted its efforts in several communities within one metropolitan area. Four projects focused their prevention and family support activities within specific geographically defined high-risk urban communities.

Project Components

NCCAN sought the following prevention approaches in this demonstration grant program (from the program announcement, *Federal Register*, June 1. 1989):

- Public awareness programs for citizens about positive parenting and positive family support.
- Prenatal health care and parenting education and support programs for all new parents (including home health visitor programs) that acknowledge and reinforce parental responsibility for their children;
- Support services for parents under stress that encourage parent participation, including child care, respite care, crisis nurseries, helplines. self-help groups and other natural helping support networks in the community, provision for linkages and continuity of care and services.

housing and other basic necessities, and job training;

- School-based age-specific prevention education programs for ail school-age children;
- Coordination lbetween child abuse and neglect services and domestic violence programs;
- Therapeutic care for victims and perpetrators of abuse; home-based transition and followup services for children and their families; and
- Projects for the prevention of alcohol- and drug-related child abuse and neglect including substance abuse as a component of parenting education and curriculum training programs.

The following three additional components also were suggested but considered optional for inclusion in the models:

- Hospital-based (or whatever health facility may be available in a rural area) information and referral services for parents of children with disabilities and children who have been neglected or abused by their parents;
- Multidisciplinary training programs for professionals involved in the planning and implementation of these model community programs; and
- A community-based interdisciplinary task force including the citizens and the private sector to plan, develop, implement, and oversee the model community prevention program.

As shown in Exhibit 1 following this page, the: nine projec ts achieved varying success in implementing the components. Only one of the demonstration projects successfully implemented all the required project components. While serious attempts were made by all the projects to provide comprehensive family support services, within their target communities, collaboration sometimes was difficult to achieve; additional resources 'were hard to develop; relationships between grantee agency, advisory council, and project staff occasionally were strained; and staff changes altered timelines and project capacities, thereby limiting projects' abilities to develop some aspects of' their demonstration models. Some or' the required components appeared to be more difficult to implement than &hers-- only four project:; provided alcohol and drug abuse counseling. while all nine implemented public awareness activities, parent education programs, and community task forces.

Public Awareness Programs.—All nine projects implemented various public awareness strategies, including public service announcements (PSAs), poster campaigns, media stories and interviews, public speaking before community groups, fliers and small giveaway items that advertised the project and its services. and newsletters distributed in the target communities, The messages presented by the public awareness strategies included (1) the need for child abuse prevention and (2) the need for increased community support for families. Two projects developed videos highlighting their projects successes and made these available to community groups and local cable television stations. Unique strategies developed by one project included a series of community-focused town meetings and a weekly local cable-access television show. Both strategies reached relatively large audiences and allowed community residents to express their concerns and interact with professionals regarding family and parenting issues

Parent Education and Home Visitation.—All projects provided some form of parent education Parenting courses often were provided as a distinct project component and offered within the target community over several weeks. The purpose of these courses was to provide formal information dissemination and opportunities for parent-parent interaction on key topics. Parent education also was provided informally through home visits, mentoring and parent-to-parent programs, dissemination of educational materials (e.g. one project developed Child Behavior Management Cards to provide parents with

Exhibit 1

Summary of Program Components

Program	Public awareness	Parent education and home visitation	Support services	School-based programs	Coordination between child abuse and domestic violence programs	Therapeutic care for victims/perpetrators of child abuse and neglect	Alcohol and drug abuse counseling	Hospital-based information and referral	Multi-disciplinary training	Interdisciplinary task force
Dorchester CARES	✓		✓				✓		✓	
PARE	✓	✓	✓	✓	✓	✓		✓	✓	✓
NLFSI	✓	✓		✓		✓			✓	✓
I CARE	✓	✓	✓		✓			✓	✓	✓
Community Lifeline Program	✓		✓	✓			✓		✓	✓
Families First in Fairfax	✓	✓	✓					✓	✓	✓
CCAPP	✓	✓	✓	✓	✓		✓	✓	✓	✓
Family Care Connection	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Project Maine Families	✓	✓	✓		✓					✓

accessible information about typical child behavior problems), and general family support and parent–child activities. Formal parent education efforts included the Parent Nurturing Program (Bavolek, 1990), the parent component of the Effective Parenting Information for Children" curriculum, and curricula developed specifically for the target population. For example, one program developed the Culturally- Based Parenting Enrichment Program,[7] and another developed a prenatal curriculum, Punto de Partida (Starting Point) [8]

Seven projects provided home visitation for families expecting a child or with young children. The home visits usually were designed to monitor the health and developmental progress of infants and toddlers and to provide family support and parenting education. In one project the home visits were part of the project's case management and were conducted by trained volunteers who mentored at-risk families; the case management portion of the home visiting program was considered essential to its effectiveness.

Support Programs for Parents Under Stress. --Eight of the projects provided parent support activities that included family resource and drop-in centers; support groups that grew out of parent education courses; negotiations for needed resources from other community agencies; transportation to attend project activities; community respite centers; social opportunities and family events; and provision of mentoring and other support through personal relationships. One project developed a laundry program that provided free laundry services every other week for teenage mothers, which also helped to decrease their sense of social isolation. Another project developed respite care centers to provide routine, temporary child care for low-income parents. Other effective strategies included family or parent cooperatives that provided opportunities for sharing of resources, responsibilities, and mutual concerns. One project developed co-ops that provided for families' basic needs while engaging them in community volunteer activities. Another project used co-ops to bring parents with similar needs together (e.g., single parents, parents of children with seizures, young-child playgroups) for mutual support and exchange of information.

School-Based Programs. --At the end of the demonstration period, five projects were providing school-based age-specific programs for youth. (One project initially provided programs in schools, then shifted its focus in the second year, when the schools' interest in the programs decreased.) The curricula provided by these projects emphasized development of life skills, enhancement of self-esteem, and promotion of positive lifestyles. One project's school-based curriculum taught schoolchildren how to protect themselves from physical and sexual abuse. The projects also provided such activities as field trips; afterschool programs that included recreation, homework help, and tutoring; and safe places and activities for those who otherwise would be left alone. In addition, the schools collaborated to provide programs to help children and youth avoid alcohol and other drugs, to improve parent–child interaction, and to increase positive school–parent interactions, as with the Parent Partner Program. Projects sometimes offered to provide prevention programs or curricula and training programs to the schools, but schools seldom accepted such help, or institutional barriers prevented such arrangements.

Coordination With Domestic Violence Programs. --- Five projects featured coordination with domestic violence programs. One project developed materials and print resources for families experiencing domestic violence; it also translated existing community resource guides on domestic

[6] Developed by the State University College at Buffalo, 340 Cassety Hall, Buffalo, NY 14222.

[7] Developed by the National Committee to Prevent Child Abuse, 332 S Michigan Avenue, Chicago, IL 60604.

[8] Developed by the Exchange Club Center for the Prevention of Child Abuse, Apartado 3256, Carolina, PR 00628.

violence programs and other resources into several languages to serve its diverse population. Another project developed a collaborative relationship with a community organization that allowed it to offer a weekly support group for victims of domestic violence. A third project specifically targeted its programs toward women experiencing domestic violence. Two other projects conducted networking and planning groups with local domestic violence programs.

Therapeutic Care Programs.-Five projects provided or coordinated some type of therapeutic care for victims and perpetrators of abuse. Successful efforts included support groups such as a mothers' therapy group and parent–child workshops on sexuality in one community, parent support groups that emphasized improving parent–child relationships for parents who were reported for abuse in another community, and Parents Anonymous groups in a third community. Although another project attempted to provide therapeutic home visitation services for families with open child protective services (CPS) cases, efforts ceased after only 8 months because the county CPS agency was unwilling to adequately reimburse the project for working with this population.

Alcohol and Drug Abuse Programs.-Four of the demonstration projects collaborated with substance abuse programs to offer alcohol and drug abuse counseling. These collaborative efforts included home-based intervention, risk assessment, linkage with treatment services and other support for families, and counseling and support groups for parents with substance abuse problems. Although the reasons the other projects were less successful at this project component were not well documented, mdividual project evaluation reports suggested that this coordination would have been too costly, little interest in collaboration was found within the existing community substance abuse programs, and the staff time necessary to implement this component would have been excessive given the modest impact that was expected.

Hospital-Based Information and Referral Programs.-One project incorporated NCCAN's original program directive to provide hospital-based information and referral services for parents of children with disabilities and children who have been neglected or abused by their parents. That project Implemented a support group for parents of children with special needs that included discussion, guest speakers, training on providing child care for children with special needs, and collection and dissemination of information on financial resources available for families with special needs. All but one of the project3 that attempted to work with hospitals experienced significant difficulties. Five projects eventually implemented at least a minimal hospital-based information and referral activity in their communities, which consisted of networking with and receiving referrals from local hospitals.

Multidisciplinary Training Programs.—All but one project implemented multidisciplinary training programs that ensured that staff members, collaborating partners, and other community agency staff had an understanding of the issues involved and their ability to perform their tasks. Such programs increased the overall scope of prevention skills within the community and emphasized child abuse prevention to other agencies serving children and families. For example, one project reported that many service agency professionals in that community had been under the impression that the CPS had sole responsibility for the prevention of child abuse and neglect. Mental health providers, parent educators, and crisis intervention service providers regarded their services as treatment oriented, not prevention oriented. This project helped to institutionalize the concept of prevention throughout the county's department of human services. In another project. participation by high-level government and private agency heads led to the institutionalization of policies for reporting child abuse in the health and education departments.

Interdisciplinary Task Force.-Although it had been an optional component, all nine projects were guided by a community-based interdisciplinary task

force or advisory council during the planning and implementation stages. Task force or advisory council membership included high level government officials, community representatives, and low-income parents residing in the target communities, as well as representatives of other social services agencies that were operating in the target communities. Target population residents sometimes were sought to participate on the task forces or advisory councils after the initial planning and project implementation; however, in the few cases where these efforts were successful, the resident,? usually joined as honorary members or as sole representatives of the community. One final project report stated that community residents had declined offers to serve on the advisory council because they felt less capable than the agency staff and other community professionals who already were serving in this capacity. Most projects were very successful in involving community residents on the committees and advisory groups of specific programs such as family resource centers, family and school events, and parent support programs.

The importance of involving members of the target population in the planning and implementation of these community-based projects was well recognized. In fact, one project considered community representation so important in continuing its prevention efforts beyond the demonstration period that it instituted a policy of mandatory community representation on its advisory council to include at least 50 percent community residents who were: not employed by participating agencies.

Community Needs Assessments

Six projects conducted formal or informal community needs assessments either before applying for the NCCAN grant or shortly after the grant award. These assessments often refocused the project's original project design to better reflect the needs of the target community. Some projects also instituted other mechanisms to provide continuous feedback, such as focus groups. One result of tailoring the projects based on community assessment information was that community residents and project participants perceived the staff to be culturally sensitive and receptive to the issues that were important to the people they served. Some projects noted that participants were resistant to outside service providers who did not establish a community presence prior to operation. In several cases, the projects developed and distributed resource directories based on the results of their needs assessments. These resource directories usually were targeted specifically to other service providers as a way to increase collaboration and referrals but also helped to educate families and link them with needed service.

Interagency Collaboration

As implemented by the nine projects, interagency collaboration involved the direct affiliation or association of the project with agencies or organizations (e.g.,, social service, medical, mental health, governmental, religious, and business) in the oversight, management and provision of prevention services. One project emphasized a collaborative approach that required the consensus of the collaborating organizations in all decisionmaking. The projects' collaborative relationships went beyond simply networking. serving on other agencies' boards of directors or providing client referrals to other agencies; they entailed a formal relationship and a team approach to providing services. In addition to identifying community service gaps, the interagency collaboration helped to minimize intrusion into the residents' lives by reducing duplicative and often competing services.

How the Projects ***Achieved Collaboration.*** —All nine projects sought and achieved at least some interagency collaboration within their target communities The projects' community-based advisory boards or councils. entrusted with decisionmaking and policymaking responsibility. guided, monitored, and delivered the projects' activities throughout the grant period. 'There was widespread recognition that such affiliations were necessary to establish a presence within the community; obtain referrals; reduce the duplication

of services; and foster cohesive, collaborative working relationships.

Each project established such relationships early. often through the solicitation of advisory board members. These interdisciplinary groups comprised key organizational representatives who worked with the projects because it helped their own agencies address child abuse prevention issues more comprehensively and avoid costly duplication of services.

The projects proposed a wide variety of agreements with local agencies and organizations and were able to solicit and maintain interagency contacts because they stressed collaboration rather than competition. Several projects spread the responsibilities and costs associated with project operation and staff across their agency members; this allowed each project to achieve more than could have been done otherwise, fostered a wider sense of ownership, and prepared for the institutionalization of the prevention services after the NCCAN funding ended.

These interagency collaborations also fostered networking to identify and secure additional assistance and funding for both the demonstration projects and their collaborative partners. These advisory boards **and** councils often were successful in decreasing bureaucratic entanglement and **in** helping to secure outside funding of either direct or in-kind resources. At least one project reported that an agency involved on its advisory council was successful in obtaining program funding due to its association with the NCCAN project.

The collaborative relationships projects were able to build with educational, religious, and other community organizations (e.g., police and fire departments) were vital to the success of the demonstration projects. Most projects shared the view that these associations and the resulting programs were more accurately seen as catalysts for change rather than as means for providing direct prevention services. In the end, the degree to which each project was able to institutionalize its programs in preparation for the post-NCCAN grant period may be the best indicator of whether the project was able to mobilize and gain the support of community organizations.

Barriers to Achieving Collaboration.—The nine projects reported a number of barriers in their efforts to achieve interagency collaboration. Their success varied widely depending on their awareness of potential conflicts and their flexibility in proposing solutions. There were multiple reasons for the problems encountered, including declining interest **and** involvement, resistance from some sectors in becoming involved in the project. high staff turnover, poor organizational management, **and** turf battles. All these issues were troublesome for all the projects, and the lessons they learned are instructive.

Some of the problems encountered with interagency collaboration were generalizable. while others arose from local conditions such as budget constraints, labor strikes, key personnel shifts, and local political dilemmas. Turf battles appeared to be a problem for most projects. For example. collaborating organizations often perceived a project as competing for resources and project participants, which ultimately led some partners to reduce their involvement. One project's solution was to formally allocate a portion of the project'\ operating funds to the partner agency, which assumed the role of fiscal agent for that effort. This internal funding mechanism was very effective for attracting and expanding other agencies' involvement with the project.

Other projects stressed that they were not new agencies and, therefore, did not represent competition with established agencies. Rather. they sought to mobilize existing resources to maximize the quality and quantity of the communities' prevention efforts. This strategy appears to have reduced some of the local agencies' resistance. The university-based projects. in particular, noted a reluctance **by** some local service agencies to view them as viable partner\. they had to stress what they had to offer to the overall effort, such as name recognition and interrelated departmental expertise.

Other successful strategies to overcome barriers to collaboration included establishing overall priorities, clearly (defining agency roles, collectively developing workplans, and recogn zing and using each partner's specific shills. Staying focused on project goals and objectives and anticipating potential conflict areas appeared to be the most successful strategies.

One project observed that the competitive nature of the external funding systems proved to be a continuous and seemingly irresolvable area of conflict. That project pointed out in its final report that applying ceilings to the amount of funding that could be requested—when the ceilings were not related to the number of people served or the: geographic scope covered—was detrimental to collaborative efforts because agencies could receive more funding by applying alone than by joining in with other agencies. Although1 this project was unable to resolve its problem, it did address the problem directly with the collaborating agencies and organizations.

Community Representation and Involvement

"Community representation" refers to relationships with a broad range of community actors, including parents, project participants, business and community leaders, volunteers, and school personnel. Each project de veloped strategies to attract and involve community representatives other than the agencies and organizations represented on the advisory board or council. These relationships generally were less formal than those developed in interagency collaboration as discussed above and required commitments of time, funding, and in-kind resources rather than professional services and government alliances.

How the Projects Achieved Community Representation.—All nine projects achieved at least partial success in involving different sectors of their communities, as evidenced by their receipt of financial and in-kind support for their activities. Support from the business community was often cash and in-kind support for specific activities such as holiday gift programs, PSAs, general advertising, printing and duplication of flyers and newsletters, donation of toys and household items, and raffle prize giveaways. Schools and religious organizations provided space for project activities and part-time staff to implement specific operations, acted as partners in increasing parent participation, and promoted public awareness of the project All but three projects also actively engaged individuals in the community to assist with the design, promotion, and implementation of the projects' activities. Individuals 'were sought as volunteers, event planner:, and participants, liaisons with parents, and advisor:,. Many of these individuals were resident:, in the target area or were local area leaders, physicians, housewives. or university students. Implicit within most projects was the assumption that strengthening families would help the whole community prosper.

Eight of the nine projects recruited community residents to help design and implement project activities. The residents included parents, project participants, volunteers, cc mmunity leaders, and neighbors of the target population. All nine projects asserted that their success was ultimately tied to the community's identification with their project's mission. The projects also found that collaboration wi th community representatives often increased community involvement, sense of ownership, and public awareness of the projects' missions and services and reduced project operating costs.

All nine projects collaborated with a broad range of community figures through several strategies that met the projects' immediate programmatic requirements. One objective of these: efforts was to gain continuous insight into the needs of target community residents to avoid developing programs that would not be accepted or used. For example, one project recounted the fc llowmg story, which highlights a potential conflict between the target population's needs and the assumptions of professionals:

> Early in the project a family advocate came to a planning meeting and described the situation of a neighborhood grandmother.

> The grandmother was caring for 12 grandchildren while her sons and daughters worked. She wanted a fence so that she could safely let the children play outside. The group around the table, mostly agency staff, discussed the situation. One person commented, "That's a lot of kids to care for." Another added, "She could use some help." A third suggested, "What she needs is a homemaker or a child care aide." The advocate reminded them, "What she wants is a fence."

Some of the most successful project-community alliances resulted from the projects' encouragement and provision of leadership opportunities for community members. For example, many projects responded to community members' recommendations for improvements to the current system. Several projects that developed new programs based on their members' suggestions generally were successful in meeting objectives, and the volunteers often required little support from the projects following the startup phase. For example, one project that began as a totally volunteer effort became the complete responsibility of a collaborative group-including a school district, two counties, and four local governments-that was organized, counseled, and facilitated by the project staff.

The overall level of participation from community representatives appears to have increased in projects where opportunities for program development and leadership were extensive. In addition, at least three projects noted that having volunteers help with programs that previously had assisted them was an added, yet necessary component; new participants could identify with peers and participants/volunteers who were able to "give something back" to the project that continued to positively affect them. By assisting other participants, volunteers also helped create an informal social support network within the target area that would strengthen the community. Finally, one project reported that by actively soliciting youth and teenagers to serve as leaders and to shape project components, the project was better able to gain young people's participation in its programs. This was especially important in light of the experience of most of the projects. which achieved very little success in persuading teens to participate in their prevention activities

Faith Community and Educational Agencies.—The faith community and educational agencies were seen as logical partners because of their shared objectives of serving children and families. Most projects tried to engage the faith community in their child abuse prevention efforts but experienced a number of barriers (discussed later). One project did successfully collaborate with churches to implement respite care centers in collaboration in each of its targeted communities Another project developed two sermon anthologies focused on family support and other prevention strategies, and these were distributed to 300 congregations in the target area; however, no information is available about how widely they were used. A third project joined with a Christian center in one of its target communities to implement a drop-in center that offered a variety of services. Those projects that did not require extensive time or management obligations from the faith community and educational agencies appear to have had more success in enlisting them in collaborative ventures.

For some programs, school commitments were large and sufficient to sustain complex, long-term programs. These commitments came in the form of parents' willingness to learn about and support the project, allocation of school personnel and space. PTA funding, and joint application with the project for additional grant money to expand and support these collaborative efforts. These programs typically were designed to increase parental and family supports as well as to prevent child abuse and neglect.

Responding to Community Needs.—Requests from community members and program participants prompted several projects to provide transportation, refreshments, and child care to increase both project participation and advisory board representation (so that community members who

needed these services could serve on the advisory board). One project noted that the failure of one of thenr program:; to be successfully replicated by an agency in another community was due partly to the fact that the other agency was less attentive to these services. Another project reported that its use of the "town meeting" format was intended to provide continuous feedback from community residents. These meetings also gave their partner agencies a forum to deliver their particular messages.

Most projects reported that they adjusted their approaches and, in some cases, their project names to better meet the needs and desires of their target populations. They discovered that the "child abuse and neglect" label tended to negatively symbolize an approach of "don't do this,"' rather than a more positive family support approach. Both residents and participating agencies responded better to the more positive approach, as measured by comments made both before and after the name changes were implemented. Most of the projects eventually came to emphasize community and familial strengths rather than weaknesses. This was true among the projects that actually changed their names as well as those that did not. Ont: project's modified motto became: "I care about myself, about my family, about my community."

Barriers to Achieving Community Representation. —A number of problems were (experienced in achieving community representation and involvement. Except for the project that implemented respite care centers in collaboration with churches, the projects achieved only limited success in mobilizing the faith community. One project explained this by stating 'that many congregations in the community were too small and lacked Full-time staff to support these efforts. In addition, some churches relocate frequently; they are highly visible one week and gone the next. Some congregations also felt that they should focus on the spiritual realm and not become involved in social or political issues. Projects tended to have better success with the larger, established congregations in their communities atncl when they requested only limited commitments of time and resources. The one exception was the project that collaborated with churches in implementing respite care centers. The primary reasons for that project's success were (1) its fortuitous riming (the project approached churches III :he community at a time when several churches were looking for an avenue of involvement in strengthening families) and (3) its persistent method of approaching churches (the project relied on regular telephone calls, in-person visits. meetings, and letters to explain its mission)

Projects also noted that turnover in key staff pre sented barriers to involvement from religious organizations as well as from the business and educational communities. For instance, there were repeated examples of key representatives leaving the area or projects having to refocus their efforts elsewhere, both of which had a significant impact on the continuation of representation and relationship:;. On the other hand, relationships with direct service agencies often were less dependent on the motivation of individual staff members

Low community representation in some projects was due: to the projects' inability to adequately integrate professional and neighborhood representatives, the subjectivity and uncertainty of continued involvement, and the low priority that some projects gave to securing representation from all sectors of the community. Two projects noted that advisory board imembership continually charged throughout the grant period, due at least in part to the inexact manner in which the projects recruited members. Projects realized benefits in maintaining flexibility regarding who was in vited to become involved and the degree of their in volvement. Flexibility increased the total number and types of members who became involved, but it also left them with less dependable board members

Another barrier was the difficulty of maintaining the involvement of community residents, especially parents, on advisory boards or councils. Many parents seemed intimidated by the professionals and by doubts about the val ue of their own

contributions. Furthermore, although parents were recruited to keep the project's focus on activities that would be useful and necessary to their peers, they did not always have the clout needed to help the project secure outside funding or network with other agencies or organizations.

Projects that were able to effectively harness and use the potentials of their diverse organizational board members reported the best results from their involvement with these groups. One project also emphasized that its success depended on both professional staff and community residents undergoing a shift in their understanding of their respective roles. Agency staff needed to shift from the role of clinical experts to partners with other agency staff and with families, and community residents needed to shift to participants in the project's design as well as recipient of services. Each project choosing to integrate the services of professional and community members was able to meet the challenges of harnessing assistance from diverse groups and redefining traditional roles and responsibilities to tackle the needs of the families they were created to serve. Although the methods employed to integrate different types of board members depended on each project's circumstances, five of the nine projects chose to include community members on their advisory boards.

Institutionalization

One reason NCCAN emphasized that the projects needed to be comprehensive and community based was to increase the chances that the communities would be able to sustain the prevention services following the termination of NCCAN funding. The nine demonstration projects had very different experiences institutionalizing project components and specific activities. In general, a wide range of community programs and activities implemented during the 5-year demonstration period continued beyond the completion of the NCCAN grant, either through the shared efforts of collaborating partners, by incorporation into the grantee agency, or through new grants developed prior to the end of NCCAN funding. In other cases, the demonstration project and its specific interventions ceased. but new efforts spurred by the existence of the demonstration project continued to provide family support and a prevention emphasis within the target communities.

Examples of the latter include a program to provide prevention services to homeless families that developed during the final stages of one of the NCCAN projects and is now supported by a corporation grant. Efforts by another project brought home visitation for at-risk families to the target neighborhood following the end of the demonstration program, which was a direct result of the services developed through the NCCAN funding.

Most of the family resource or drop-in centers continue to operate in their target communities. and many still offer the same services they provided under the NCCAN grant. Several school-based approaches developed by one project were incorporated into the city's school system before the end of the demonstration period. For three projects, effective project components such as parenting education and home visitation were picked up and funded through State or county agencies. In one case, the community's concern for adequate family support was incorporated into a resident-driven committee of the city council through the specific efforts of the demonstration project staff; this happened when other project components failed to gain financial support from community and State sources.

In general, the more involvement a project generated among community residents and volunteers, the more likely it was that essential elements of the project would continue beyond the demonstration period. Use of volunteers or other involvement of community residents in the prevention activities was both a strategy that increased ownership and a philosophical approach to implementation that may have prompted local funding sources to provide resources for project continuation.

A few projects trained significant numbers of community residents to implement project components. such as one project that trained more than 700 volunteers as parent partners. Such training contributed to the success of the demonstration project and gave ownership of project strategies to those who lived and worked in the communities. The skills and social capital developed by these involvements tended to remain in the areas where they were generated to maintain an emphasis on child abuse prevention

ASSESSMENT OF PROJECT EFFECTIVENESS

The nine projects evaluation designs were very diverse, as their comprehensive nature required multifaceted evaluation approaches. Some activities lent themselves more readily to quantitative outcome measurement, others to rich descriptive methods (e.g., m-depth interviews with project participants), and still others to data collection using focus group discussions involving knowledgeable community collaborators and service providers. Parenting education classes often were evaluated with a pretest/posttest questionnaire that measured changes in knowledge, attitudes, and behaviors occuning during the intervention. However, the effects of public awareness campaigns would have been difficult to capture using a pretest/posttest questionnaire due to the large target audience and the projects' limited evaluation resources; therefore, such interventions usually were evaluated through key informant interviews or focus group discussions,.

Data Collection Methods

Exhibit 2 following this page shows the various outcome data collection methods employed by the projects. Note that this exhibit includes outcome data collection pertaining to program effects on participants, not process data collection documenting the projects' implementation and operation. Data that pertain to the process evaluatran rather than the outcome evaluation include information on (1) participant satisfaction, characteristics, needs, perceptions of the project, or reasons for using; the project's services or products; (2) the degree to which the interventions actually reached the target audiences; (3) how participants found out about or 'were referred to the projects; (4) use of project services or products; I 5) community awareness of the project; and (6) participant or target community risk indicators (rather than outcomes). The projects collected extensive process data, much of which was incorporated into the previous section of this chapter on project implementation. The outcome data were primarily qualitative or descriptive, although some quantitative outcome data were collected through administering pretests/posttests to project participants and through interviewing or surveying project participants or target community residents.

Six projects collected quantitative pretest/posttest data from project participants without using comparison groups. Most of them were unable. for a variety of reasons, to obtain definitive results and instead relied on qualitative data to tell their stories. For example., two projects administered the Child Abuse Potential Inventory (CAR) to parents participating in parenting programs or to clients of minigrant recipient organizations; two projects administered instruments based on their parenting or school curricula.; and another project administered a questionnaire derived from informational cards given to participant parents. However, these data were problematic for measuring program outcomes. The problems included small sample sizes, high numbers of invalidity warnings,, few matched pretests and posttests, and inconsistent use of instrument:;. Some projects administered1 instruments only at the end of project participation and used no comparison groups, which provided no evidence that the project caused the results that were presented. Other problems experienced by the projects are discussed later in this report.

The only project that employed a pretest/posttest design with a comparison group selected a nonparticipant group that was matched on demographic characteristics to the participant

Exhibit 2

Outcome Evaluation Data Collection

Program	Pretest/posttest of program participants		Time series assessments of program participants	Key informant/ stakeholder/ participant interviews or questionnaires	Focus groups	Surveys		Other quantitative data	Descriptive or anecdotal information
	With comparison group	Without comparison group				One-time	Repeated		
Dorchester CARES				✓[1]			✓[2]		✓
PARE		✓[3]		✓[4]					✓
NLFSI		✓[5]		a	✓[7]		✓[8]		✓
I CARE		✓[9]					✓[10]	✓[11]	✓
Community Lifelines Program				✓[12]		✓[13]			✓
Families First in Fairfax		✓[14]	✓[15]					✓[16]	✓
CCAPP		✓[17]		✓[18]	✓[19]				✓
Family Care Connection	✓[20]	✓[21]						✓[22]	✓
Project Maine Families				✓[23]	✓[24]	✓[25]			✓

Key to Exhibit 2

[1] A sample ot participant families and a matched sample of nonparticipant families were interviewed for information on family relationships, the social ecology of the neighborhood, and changes in the families due to participating in the program. The instruments included the Adult-Adolescent Parenting Inventory, the Child Abuse Potential Inventory a Family History Interview., questions from the Ontario Health Supplement, the General Health Questionnaire, the Conflict Tactics Scale, the Parental Acceptance Rejection Questionnaire, the Five Minute Speech Sample, the Home Conditions Rating Scale, the Maternal Social Support Index. a modified form of the Simcha-Fagan Neighborhood Questionnaire, and the Neighborhood Questionnaire as well as questions for participants pertaining to the respondents' experience with the program.

[2] Annual (1991-1993) household surveys of a random sample of target community residents were conducted using questions from the Ontario Health Supplement, the General Health Questionnaire, the Conflict Tactics Scale, the Parental Acceptance Rejection Questionnaire, the Five Minute Speech Sample, the Home Conditions Rating Scale the Maternal Social Support Index, a modified form at the Simcha-Fagan Neighborhood Questionnaire, and the Neighborhood Questionnaire as well as questions pertarning to the respondents experience with the program.

[3] The grantee's instruments based on the school and prenatal curricula were administered to participants in the curricula; for the parent aide program, the Piers-Harris Self-Concept Scale and the grantee's own "Scale for Needs Assessment and Goals" were administered to participants and preprogram/postprogram videolapes showing mother-infant interaction were analyzed.

[4] Staff of area service agencies completed questionnaires on the effects of the prenatal curriculum on participants.

[5] The Child Abuse Potential Inventory was administered to parents participating in the parenting education (CPEP), and the Instrument for the school curriculum (EPIC) was administered to students receiving the curriculum

[6] Key informants were asked about the impacts of the newsletters, town meeting:;, school curriculum (EPIC), parenting program (CPEP), resource directory. and mass mailings. Teachers answered questionnaires about changes in their students after participating in the EPIC 'curriculum.

[7] Focus group discussions were held with participants in the town meetings, youth conferences, and CPEP and EPIC parent classes regarding the effects of the interventions.

[8] Preprogram (1990) and postprogram (1995) surveys of community agencies elicited information about family support services in the target community and how they changed over the period of the NCCAN grant.

[9] Families enrolled in the home visitation program were administered the grantee's instrument, the Child Behavior Management Questionnaire. based on the Child Behavior Management Cards.

[10] Door-to-door preprogram (1990) and postprogram (1995) surveys of target community residents were conducted to obtain information regarding discipline methods and community support.

[11] Data were collected on children's development through height and weight checks and through administering the Denver Developmental Screening Test.

[12] Interviews were held with program staff, grantee staff, program organizers, teachers, school administrators, volunteer facilitators, program participants, and representatives of other human service agencies regarding the effects of the interventions on children, parents, and schools.

[13] Teachers were surveyed to obtain descriptive information about changes in student attitudes after the students and their parents participated in the program interventions.

[14] The Nurturing Quiz, Adult-Adolescent Parenting Inventory, and Child Abuse Potential Inventory were administered to participants in the Parent Nurturing Program. The Family Stress Checklist was completed at intake and case termination for families participating in the Healthy Start Phase I program,,

[15] The Denver II instrument was intended to be administered at 6. 12, 18, 24, and 36 months of age for the target children of families participating in the Healthy Start Phase I and Phase II programs. The Difficult Life Circumstances and the Community Life Skills Scale were intended to be administered at intake and thereafter annually to participants in the Healthy Start Phase I program. The following instruments' were intended to be administered on various time series

Key to Exhibit 2 (continued)

schedules to families participating in the Healthy Start Phase II program: Parenting Stress Index. Child Abuse Potential Inventory, General Functioning Scale, Community Life Skills Scale, Difficult Life Circumstances, Network Survey, NCAST Feeding Scale, NCAST Teaching Scale, HOME Inventory, and Infant/Child Monitoring Questionnaire.

[16] The program examined records of immunizations and Child Protective Services statistics.

[17] The program administered the Child Abuse Potential inventory to clients of the minigrant recipient organizations

[18] A sample of administrators of and participants in the minigrant programs were interviewed regarding the effects of program participation.

[19] A sample of administrators of and participants in the minigrant programs participated in focus group discussions regarding the effects of program participation.

[20] Samples of drop-in center program participants and residents of a comparison community completed the Maternal Social Support Index and the Child Well-Being Scales.

[21] Participants in the parenting classes completed the grantee's instrument based on the parenting education curriculum

[22] The program examined low-birthweight rates in target communities

[23] Program participants, community collaborators, and service providers were interviewed regarding the effects of program participation.

[24] Program participants, community collaborators, and service providers participated in focus group discussions regarding the effects of program participation.

[25] Community agency personnel were surveyed regarding the effects of the program on them personally and professionally; program staff and participants were surveyed using the Family Empowerment Scale.

group. That evaluation's data had not yet been reported as of this writing.

One project collected quantitative outcome data through annual community surveys on community changes during the NCCAN grant period. This project also obtained quantitative outcome data on the effects of project participation through in-depth interviews with selected project participants and a matched comparison group of target community members. Due to a lack of resources to conduct data analyses, the project did not report most of the quantitative outcome data that were collected, although a few possible program effects were mentioned.

Three projects reported quantitative data, collected by other agencies, that possibly pertained to their anticipated outcomes. These data included child immunization records, CPS records, and low-birthweight rates in target communities.

Qualitative data were collected by various methods including interviews with or questionnaires administered to key informants, stakeholders, or participants; focus group discussions with staff, participants, service providers, and community members; and surveys of community residents, community agencies. teachers, project volunteers. and project participants. One project used qualitative data exclusively, employing a stakeholder evaluation design that relied on extensive interviewing of staff, participants. volunteers, school personnel, and other agency staff to elicit descriptive information on program effects. Much of this qualitative data provided compelling testimonies to the positive effects of the project on the participants, other community agencies, and the communities themselves. This qualitative and anecdotal Information is too voluminous to be included in this report but can be found in the projects' own final and evaluation reports (see Barnes and Shay, 1995; Center on Child Abuse Prevention Research, 1994; Children's Hospital of Pittsburgh, 1995; Crittenton Family Services, 1995; Massachusetts Committee for Children and Youth, 1995; Project Maine Families, 1995; Ray and Grzelkowski, 1994; Rosenthal, 1995; Strouse, 1995; and Vázquez Ruiz, 1995).

Outcome Findings

Evaluating the effectiveness of prevention programs is especially difficult when evaluators must measure behavior that has not occurred (i.e., child abuse or neglect). How can the evaluator confidently attribute the results solely to the program? The evaluator must differentiate between parents who would never have abused or neglected their children in the first place and those who probably would have had they not received the intervention. An experimental research design, involving randomly assigned control groups, can help produce meaningful results; by comparing program participants to a control group with similar characteristics, the evaluator controls for nonprogram-related factors that may result in the absence of child maltreatment. However, researchers have noted that adopting the experimental model can be unrealistic and counterproductive in a field study where conditions cannot all be controlled and where data collection must adapt to the complexities of social communities (Moskiwitz, 1993) Thus, quasi experimental research and descriptive and qualitative information—including collecting time-series data and administering pretests and posttests with no comparison groups---can play an important role in documenting a prevention program's effects. The nine NCCAN projects rely primarily on such information in their evaluations.

One type of outcome data chat appears pertinent to the goals of the NCCAN projects and that requires no testing of program participants—rates of reported child abuse or neglect cases—was rarely monitored or analyzed in project evaluations. although one project followed CPS reports on its project participants. Reasons why child abuse and neglect reports generally were not tracked include the following: (1) the often biased nature of child maltreatment reporting data makes them undesirable for evaluation purposes; (2) poor families are much more likely than middle-class families to reach the attention of social services

agencies; and (3) investigating a child abuse or neglect report may be the best way to obtain services for families, so families with more resources of their own are not investigated to the same extent, which further biases CPS data.

In addition, child abuse and neglect statistics often are difficult to analyze due to incomplete information about the nature of the maltreatment. where it took place, and the outcome of the investigation or the services provided. Finally, many of the interventions provided by the nine projects were intended to influence intermediate variables, such as parenting knowledge or parent stress level, and it was likely to be many years (if ever) before the interventions had an impact on the ultimate goal of preventing child abuse and neglect (to the extent that CPS rates were affected). None of the evaluations (i.e., the cross-site evaluation or the projects' own internal evaluations) was designed to last that long.

Therefore, the projects examined a number of individual outcomes and some community outcomes, rather than data on child abuse and neglect reports. The individual outcomes included parents' social support, knowledge of child development, and attitudes toward disciplining children and children's school performance and motivation, knowledge of risky and self-protective behavior, self-concept, decisionmaking skills, and social skills. Community outcomes included interagency networking and cooperation.

Individual Outcomes.—One project conducted annual neighborhood surveys that revealed a small but steady increase in social supports within homes and between friends and neighbors in the target area. The surveys also revealed that the extent to which neighbors monitored neighborhood children or watched out for each other was stable over the NCCAN grant period. Although the project had hoped to observe an increase in those indicators, it claimed success because families remained stable; they did not retreat from their neighbors to cope with pervasive neighborhood socioeconomic declines. The project reported that the data on indicators of abusive or hostile parenting were inconclusive and suggested that it would be more pertinent to measure changes in parenting practices within a family rather than to look for communitywide changes. Qualitative data from interviews with project participants illustrated the importance to them of having a home health visitor who shared their cultural background, access to a food pantry, and a place where they could share struggles with other parents.

Another project conducted participant focus group discussions, key informant interviews, a community agency survey, participant questionnaires, and pretests/posttests of school and parent curricula. Participant, key informant. and community agency feedback indicated (in a very tentative way) that the project's interventions achieved some positive changes such as greater citizen involvement in community activities, some reduction in youth crime and violence, Increased community awareness of child maltreatment. and enhanced agency networking. Some parents also reported that they had stopped using corporal punishment with their children as a result of participating in the curricula, although the CAPI scores on this issue were inconclusive. The pretests/posttests of the school curriculum and the teacher questionnaires showed that students tended to improve their scores in the areas of self-concep:. citizenship, and decisionmaking.

One project administered a pretest/posttest questionnaire to document changes in parents' knowledge of child development and behavior management over the course of a home visitation program. Both pretest and posttest scores were available for only six caretakers; five showed increased knowledge of the material covered by the questionnaires, while the sixth had a lower score at posttest than at pretest. The evaluation report cites questionnaire administration problems as preventing the accurate collection of data on the parents' knowledge of child development and behavior management issues. That project also conducted two community parenting practices surveys, one at the beginning of the project and one 5 years later. The results showed that the proportion of interviewees who used spanking as a

method of discipline declined from 63 percent in 1990 to 53 percent in 1995, while the percentage taking away privileges increased slightly from 70 percent in 1390 to 75 percent in 1995.

One project used a stakeholder evaluation model Qualitative data obtained through interviews with stakeholders (e.g., project staff, project organizers, volunteers, school staff. parents, and representatives of agencies who had contact with the project) revealed that participation in that project had the following effects: (1) teachers reported improvements in children's performance and behavior; (2) principals reported improved communication with parents; and (3) teachers and principals reported increased parent involvement in the schools. These interviews suggested that participation in the project's neighborhood initiatives increased cooperation among community agencies, Including town and county governments, schools, and other human services agencies and organizations.

A project using the Parent Nurturing Program (Bavolek, 1990) conducted a pretest/posttest evaluation which revealed that participants in the early childhood (ages 3 to 12) program significantly increased their knowledge of behavior management techniques, w hile their parenting attitudes and beliefs were not significantly enhanced. Overall, participants felt that their participation had changect their lives by encouraging and promoting therr self-growth and development. The project also evaluated Phase I of its Healthy Start program, which showed that the mothers levels of stress decreased significantly from the end of their first year of participation to the end of their second year of participation, while their levels of self-sufficiency increased significantly over that time period. That project also monitored CPS reports on its project participants; 92 percent of the participants had no CPS reports of child maltreatment after 2 years, of project participation, and none of the clients who entered the Healthy Start program with a previous CPS report had a subsequent report in the 2 years following entrance into the program.

Another project. which awarded minigrants to community organizations, conducted interv iews and focus group discussions with administrators of and participants in thr minigrant programs. Descriptiv e information indicated that many administrators and participants felt that the programs did help reduce distress, loneliness, rigidity, and lack of knowledge, all of which are associated with the incidence of child abuse. The project also admini stered the CAPI on a pretest/posttest basis. but most of these could not be matched. and the evaluation results were inconclusive.

One project that sponsored community drop-in centers used a pretest/posttest evaluation with a comparison group. Samples of drop-in center project participants and rttsidents of a comparison community completed the Maternal Social Support Index and the Child Well-Being Scales on a pretest/posttest basis, but the data had not been reported as of this writing. Participants in some of the parenting classes also completed a pretest/posttest instrument developed by the project and based on the curriculum. Most parents who completed the instrument reported that they would be less likely after participating in the project to use physical punishment when disciplining their children 'The project also examined low-birthweight rates in two ot' the target communities and found that they dropped substantially during the NCC AN grant period.

A project sponsoring a laundry program. a school center, a program for parenting high school students, and numeirous community events conducted interviews and focus group discusstons with project participants, community collaborators. and service providers. Project staff found that laundry program participants began using available social services they had not previously used and that these mothers' children improved their social skills through participating in the day care program. In addition, interviews with community collaborators indicated that, because of theirr invo vement with the project, 87 percent had made changes ir how they worked with families (e.g., they began using programs that targeted family problems and needs, and they increased the

support they provided to the parents). In addition, their awareness of the problem of child maltreatment had shifted to seeing that prevention was a community concern, not just a CPS concern.

Another project, which implemented a school curriculum, a prenatal curriculum, respite care centers, and a parent aide program, collected data through pretests/posttests of project participants, questionnaires administered to prenatal clinic staff, and interviews with participants. Pretest/posttest data for the school curriculum revealed a small but statistically significant increase in knowledge about risk factors and self-protective behaviors for children in kindergarten through second grade, but no increase was found for older children. Pretest/posttest data for the prenatal curriculum showed that participants significantly increased their knowledge about the behavior of children in stressful situations and how to control children's behavior without being abusive. Pretestfposttest data on the parent aide program showed no significant difference in self-concept, while an analysis of preprogram/postprogram videotapes (made at 4- to 6-month intervals) showing mother-infant interaction revealed an improvement in bonding in 4 of the 13 mothers, no change in the 7 who showed positive bonding in the first observation, and signs of some decrease in bonding behavior in the remaining 2 mothers. (Depression, uncomfortableness, insecurity, and ambivalence were noted in the postprogram videotape, and those mothers were referred for special services from the project.) Most of the clinic staff who completed questionnaires concluded that the curriculum had a positive impact on the participants' knowledge about pregnancy, child development, and child behavior management. Interviews with participants in the respite centers led the project to conclude that the centers were an effective approach in alleviating stress that could lead to child abuse or neglect.

Several projects indicated that parents or volunteers experienced personal growth as a result of their involvement. For example, one project found that several parents decided to remain in a very transient neighborhood because of their connections with the project. The project reported that some parents were inspired by parenting courses to become involved in community activities; as they became involved, they strengthened their support systems, found an antidote to isolation and distrust, and, due to collaboration that existed between the community agencies and the projects, availed themselves of other services that they had not previously used. Projects also reported that staff and community residents experienced personal growth from their involvement in the projects. For example. in a project with a university grantee agency, staff worked with grassroots leaders to help them apply to and enroll in the university to pursue their degrees.

Community Outcomes.—One major objective of the NCCAN grant program was to design projects coordinated on a communitywide basis. That is, they should seek to network with and involve many community service providers, including schools, hospitals, substance abuse treatment and prevention programs, religious institutions, and community volunteers. NCCAN was interested in learning about how the projects impacted the communities, focused community resources on the prevention of child maltreatment, and enhanced the service delivery systems in the communities.

Project activities impacted their communities in many ways. In terms of enlarging its geographic area, one project reported that its activities had expanded from one to five census tracks over the 4-year period and in so doing encompassed an area with nearly 20,000 people and more than 4,000 families. Other types of impacts included an increase in the communities' capacity to recognize and deal with child maltreatment; improved service delivery systems; increased community involvement through volunteerism, financial support, and providing necessary goods and services; enhanced personal growth of staff and volunteers; and project-specific community impacts. Although most of the projects did not measure community outcomes, the majority (seven of nine) did report descriptive information about the positive impacts on their communities is

a result of their project Two projects provided no documentation of their projects' community impact.

Six of the projects noted that residents, community leaders, and community agencies learned how to recognize and address underlying issues pertaining to child maltreatment. This involved an increased awareness of the magnitude of the problem of child maltreatment as well as of the links between various social systems, Leading to recognition that prevention is a community concern rather than the responsibility of one agency. In one project, policies for the reporting of child abuse and neglect were institutionalized within the State Departments of Health and Education. On the final round of site visits, conducted up to a year after the projects' NCCAN funding had ended, CSR found that many community organizations brought together by the NCCAN projects were still meeting regularly and referring clients to one another. Through the projects' efforts, community leaders and agencies had been brought together, often for the first time, and they recognized the importance of continuing their networking efforts

Seven of' the projects indicated that service delivery in the community was enhanced as a result of their projects. These changes took several forms, as corroborated by CSR's findings. As a result of projects' activities., there were new requests for services, and community agencies---especially those that partnered or collaborated with the projects---were able to add to or create new programs t hat targeted family needs or provided increased support for parents. Examples of such initiatives include the formation of a bilingual and bicultural parent education program for Cape: Verdean families and the (creation of ongoing parent support groups. Community agencies also took; advantage of the training and technical assistance provided by the project staff.,, which enabled these agencies to begin new initiatives and mret the increased demand for services that occurred as a result of the NCCAN initiatives. In addition, many of these partner agencies found that as a result of their connection to the grantee agencies, they had more credence to seek out nerdcd resources and were able to obtain additional funding for playgrounds, summer programs, and other activities.

As a result of the increased involvement of community agencies that had not previously directed their efforts toward child maltreatment prevention, CSR found that more resources were brought into communities, and a broader based community network of services was available. For example, several projects continued their prevention efforts beyond the NCCAN grant by obtaining funding from foundation:; and from county, State, and Federal agencies. Some organizations that had worked closely with the NCCAN projects also were able to obtain funding often because of their association with the projects In addition, because of increased knowledge about the factors of maltreatment and about staff in other agencies, community agency staff made more referrals to other agencies. Rather than calling only the child protection agency when a family was in need of services, some projects reported that agencies referred to other appropriate community agencies more frequently than they did prior to the inception of the NCC'AN projects. Finally, task forces formed by the projects provided a coordinating mechanism for community agencies as well as a means of overcoming turf and bureaucratic barriers and in many cases they continued functioning well beyond the NCCAN funding, as confirmed during CSR's final site visits

There were also community-specific impact:; de pending on the nature of the project. 0 ne project that provided parent partners as liaisons between families and the schools and school-based outreach activities found that as a result of their efforts, connections between school*, and parents were improved, which led to improved school pet-Fbrmance by children and improved relations between parents and their children. 'Tensions between parents and schools were defused. permitting parents and school staff to view each other in a more positive light. Fun e vents for families scheduled in the school buildings helped to make the school a more

supportive and friendly place. Finally, as a result of these programs, the schools were able to become more of a resource to families and the community itself.

Several projects were able to initiate new services in a cost-effective manner that benefitted the target communities. In one project, establishing drop-in centers (all of which continued after NCCAN funding ceased) meant that the residents of the communities had "one-stop shopping" access to a wide range of family support, education, and recreation activities-something that the communities did not have before the project. In a project that had a university grantee agency, project activities helped improve relations between the university and the surrounding community; the university expanded its mission and its definition of its target population, and the community, benefitting from the technical assistance provided, improved its image of the university. Several projects were able to produce resource directories which provided agency staff, schools, churches, and community residents with information regarding the services and resources that were available for families in the community.

Although projects made positive impacts on their communities, they also had to deal with various types of community resistance. In *one* project, staff attempted to involve the police in protection and neighborhood watch activities, but Latino residents of the community were uncomfortable working with the police due to the immigration issues they faced. Another community had no success in setting up an interdisciplinary training team because this type of structure was not perceived as needed by the community. There were barriers in providing training and curricula to school personnel due to external factors such as teachers' disputes and school regulations about the curricula. In one community, emergency room physicians resisted changing their practices. Finally, turf issues presented difficult challenges for some projects. Many community agencies had long histories of relationships with other community agencies, some of which were positive and others that were full of conflict. Overcoming these barriers required staff to develop expertise in negotiating in community-based settings and to stay clearly focused on project values that emphasized collaboration and community involvement.

Problems Experienced in Conducting the Evaluations

The projects had difficulties in several areas that compromised the quality of their evaluations. Only one project used an appropriate comparison group, and the data from that evaluation have not yet been reported. In addition, the projects' evaluations often did not follow scientific rules for sampling, measurement, data collection, and analysis to produce the sort of evidence necessary for drawing conclusions regarding project effectiveness. Specifically, they experienced the following problems:

- *Lack of linkage between interventions and the measurement of child maltreatment* outcomes.-The projects had difficulty selecting specific variables to measure due to the large number of possible variables that could be expected to change as a result of the interventions. Also, the projects aimed to achieve changes in the communities, and measuring such community changes is enormously difficult.

- *inappropriate and/or inconsistent use of research instruments, or use of instruments that did not fit the interventions or were not culturally sensitive.-The* projects had a difficult time finding instruments that measured what they were trying to achieve and that were appropriate for the target population. Seven of the projects located or developed research instruments that they felt were appropriate, but the instruments were inconsistently or incorrectly administered by at least four of those projects.

- *Staff anxiety about or resistance to evaluation.*—In general, the projects' staffs were unfamiliar with evaluation and data collection procedures. Staff turnover at some of

the projects also interrupted data collection and evaluation procedures

- *Communication problems between staff and evaluators.*—The local evaluators sometimes were unfamiliar with the project's history, interventions, or staff and made little progress during the grant period in learning about the project and establishing rapport with the staff.

- *The evolving nature of' the interventions.*—The nine: projects were demonstrations, meaning that they were expected to and did evolve over time One requirement for obtaining convincing evaluation findings is that the project under evaluation be stable and fully implemented The fact that the nine projects were changing in response to conditions in their communities, feedback from participants and staff, and experience gained as project activities occurred often meant that evaluation designs had to change midprogram to tit the evolving interventions. This often necessitated changes in data collection methods and usually precluded collection of baseline or pretest data.

- *Very small sample sizes.*—Two of the projects found that even paying incentives to participants for completing the pretests/posttests was not enough to achieve a sufficiently large sample size to conduct data analysis. Project staff reported that many target communities perceived that they had been "over -studied" and very little had been gained in return, and so they were reluctant to cooperate with another evaluation. In addition. project.4 often experienced sizable attrition rates so that the pool of project participants became very small

- *The one-time nature of mani of the interventions.*—It can be difficult to achieve any measurable change in attitudes or behaviors with one-time activities. Even for those activities that occurred more than once. such as parent education groups, attendance often was inconsistent or sporadic:. Program effects from one-time activities or inconsistently-attended activities can be difficult to document.

- *Insufficient resources budgeted for evaluation.*—Projects found that they had budgeted too little money for evaluation activities, and had difficulty conducting evaluations even with additional NCCAN funding provided specifically for evaluation

Although community-based projects such as these may not follow established scientific procedures for evaluating their effectiveness, they can conduct meaningful research that provides important insights into the changes they achieved in their communities. Despite the problems the projects experienced with their evaluations, their experiences provide a rich source of information on which policymakers and other agencies can build to implement an effective child maltreatment prevention program. Important lessons Hear-ned and policy implications of the projects' experiences are discussed in the next chapter.

CONCLUSIONS

One of the goals of the NCCAN demonstration program was to produce compelling evidence for policy and program decisions regarding what community-based collaborative activities successfully focus resources on preventing child maltreatment and why.[9] The experiences of the nine projects point to a number of issues that are important in successfully implementing prevention programs. They also suggest several themes that have important policy implications. This chapter presents these implementation issues and policy implications.

VITAL PROGRAM ELEMENTS

The experience of the nine NCCAN projects strongly supports the finding that the following program practices are important ingredients in community-based prevention. programs: emphasizing community involvement and ownership, employing a positive approach, starting on a small scale, and implementing a strong evaluation and using it as a program management tool. Each of the first three practices warrants further study, with more rigorous evaluation designs, to allow for stronger conclusions regarding their effectiveness in mobilizing successful community-based collaborations to prevent child maltreatment.

Be of the Community, Not Just in the Community

Community collaboration and ownership must be an integral part of a project's design. Community residents and community-based organizations must contribute ideas and be involved in choosing, designing, and implementing services throughout the life of the project so the project will reflect community values and norms as well as address the real needs of the community. Community organizations must be enlisted as collaborators to avoid service fragmentation and to enhance rather than duplicate existing resources. The projects found that achieving the necessary collaborative relationships required them to stress, from the beginning. that they were a collaborative effort; to emphasize the community's existing resources; and to strive to enhance the use of the existing resources.

The nine projects implemented the following strategies for achieving community collaboration and ownership and encountered several barriers to be overcome.

Use a Community-Based Advisory Council.—All the projects reported that the development of and ongoing commitment to an independent community-based advisory council or task force was a key element in achieving community cooperation, involvement, and ownership. These advisory councils were responsible for guiding and monitoring all project activities, **and** they helped to ensure that the projects' interventions were chosen with the communities. The projects used the following strategies to create effective advisory councils:

- Require members to participate in developing goals and objectives and ask them to take responsibility, and in some cases share the costs, for at least one objective;
- Maintain a strong commitment to empowering other community agencies to better coordinate and deliver services to the community;
- Include members from all levels of organizations, not just executive directors;

[9] Request for Proposals No. 105-92-1808 noted that the cross-site evaluation was to "...examine the extent to which the grantees* programs have: (1) successfully focused community resources in a more coordinated manner on the prevention of child abuse and neglect and institutionalized comprehensive prevention approaches in the community, and (2) effectively used the various program components to mediate and impact upon child maltreatment."

- Include parents and community members who are not staff with other agencies;
- Develop a spirit of camaraderie and gain cooperation through annual weekend retreats; and
- Require members to attend a mandatory number of meetings to remain in good standing

Reflect Community Characteristics.— -Another element critical to programmatic success was that the project interventions, staff., and evaluation methods recognized the cultural, linguistic, and social uniqueness and characteristics of the target communities and that the projects implemented and adapted programs that were appropriate The projects found that it was advantageous to hire staff indigenous to the community, people who were known to the community and who had community organizing and outreach skills. These individuals shared the experiences of the target populations-they lived in the same neighborhoods, were ethnically and socially compatible with the target populations, and knew what would be successful The project.!; often hired people who "graduated" from the project itself because these individuals were accepted by the families in the community and knew how the target. community was likely to respond to the interventions. The projects also confirmed that curricula developed for parent education and for school-based programs must be culturally appropriate. When a curriculum fostered cultural awareness and pride among participants, it met with greater acceptance and appeared to have more impact.

Develop Partnerships by Crossing Boundaries.— Becoming an integral part of the target community often required crossing agency and hierarchical boundaries. It required attitude shifts on the part of staff, community organizations, neighborhoods, and families. Staff had to move beyond understanding their role as experts to thinking of themselves as partners with the families and with other organizations. Community residents and families had to shift from being only recipients of being participants in the program's and implementation. One project included. as part of the program structure. periodic focus group discussions with various groups of parents (e.g., working parents, teenage parents, new parents, and low-income parents) to find out what the parents' concerns and needs were and the best ways to address them. Another project maintained its collaborative structure by not becorning, an incorporated entity: member organizations served as fiscal agents for the collaborative's funding, and decisions were reached through the consensus of all collaborative members.

Devise Creative Strategies.—The NCCAN projects used many other creative methods to involve the communities and enhance community ownership. These included the following strategies:

- Awarding minigrants to grassroots community-based organizations to enable the organizations to provide needed community services and activities;
- Using community volunteers in neighbor-to-neighbor approaches, town meetings, cable television programs, parent support groups, community events, and conferences planned and implemented by local 'youth;
- Developing close collaborations or partnerships with organizations that the target communities held in high esteem and that could "vouch" for the project;
- Establishing partnerships with and placing services in local schools and churches,;
- Obtaining donations and involvement from the local business community;
- Co-sponsoring community event:!; and other programs with community organizations, especially those providing positive family experiences at Little or no cost to the participants;

- Participating in community referral networks, including the agencies involved with the task forces or advisory councils;
- Employing a sensitive, friendly approach in all contacts with community organizations;
- Making all project activities easily accessible to the target community and including transportation and/or child care; and
- Addressing pressing needs of the target families, such as food, housing, laundry, and recreation.

Overcome Barriers Through Patience and Consistency.—In many economically stressed communities, service providers jealously guard their turf and fiercely compete for limited resources. In addition, community residents often are distrustful of new programs because they repeatedly have seen programs come and go due to the vagaries of funding. In some cases, the NCCAN projects found that community distrust of the grantee organization (due to perceived lack of sensitivity to or involvement in important community issues) hampered their ability, early on, to implement and operate their programs. Finally, the projects found that the involvement of some community agencies often depended on the interest, personality, and contacts of particular individuals in the agencies; if those individuals left or their interest or availability decreased, the involvement of that agency ceased.

These factors made collaboration a slow process that required patience, time, consistency, and a constant focus on visibility and credibility in the community. In addition, some projects decided to refrain from implementing services until they felt they would be able to provide them on a long-term basis, so as not to exacerbate community suspicions about the "fly-by-night" nature of social service programs. These factors presented barriers to the projects in achieving their long-term goals.

Emphasize the Positive

The NCCAN projects found that positive programming that identified and built on family and community strengths was more effective than prescriptive approaches. The following strategies were used to emphasize the positive.

Use a Positive-Sounding Name.-The NCCAN projects confirmed that a positive approach began with their project name. They found that they had to avoid using a name that contained the term "child abuse" because many people would avoid associating with a program with such a name. They also had to avoid using the term "prevention" because people would wonder what the program intended to prevent. Many projects recast their names to more positive forms that connoted support and collaboration. Projects began using such names as "Project Maine Families." "Families First," "Family Support Initiative," and "I CARE." The name changes often indicated a deeper shift in program emphasis, from strictly focusing on child abuse prevention to a broader focus on family support. The projects viewed this shift as a critical step toward achieving their goals and objectives within their communities.

Recognize and Build ***on Community Strengths.-*** The projects emphasized that even at-risk. highly stressed communities had strengths and resources that could support the projects' efforts. Although it may have required concerted efforts to uncover these strengths, the payoff in community empowerment made the efforts worthwhile. Community strengths uncovered by the projects included (1) strong neighbor networks built on the sharing of a cultural background; (2) energetic and dedicated volunteers who were determined to make a difference in their communities; (3) struggling families who cared deeply about raising healthy children; (4) influential **and** respected community leaders who believed in the importance of family issues; and (5) vibrant and creative community organizations (e.g., churches, health centers. drug treatment programs, Head Start programs. and social service agencies) that were providing urgently needed services under difficult condition\.

Accessing these community resources was critical; in establishing effect ive projects

Provide Family Recreational Opportunities. —The projects found that incorpor-ating fun and recreational events geared toward the entire family was essential to building program participation and achieving program goals. People were not likely to participate in activities that were located in a place where they were uncomfortable (e.g., many target parents did not feel comfortable in schools) or to attend programs that focused on difficult topics such as disciplining misbehaving children, unless there were opportunities for enjoyment and relaxation. Project staff found that sharing fun and 'laughter strengthened their bonds with the families and enhanced the sense of community. These events also encouraged growth of informal friendships and development of stronger social networks to decrease the social and geographical isolation that often correlated with child maltreatment.

Anticipate Potential Negative Consequences.—The projects' efforts sometime:, were sabotaged in unanticipated ways. For example, public service announcements about child maltreatment raised public awareness about child abuse but. in some cases, upset children or created a judgmental atmosphere about "good parents" and "bad parents" that drove patents away from the projects. Several projects held activities in local schools, believing they were a convenient, familiar, and comfortable location, but some found that target parents were uncomfortable in schools and avoided the projects' activities because of their own unpleasant experiences as students. Finally, CSR's findings suggest that the involvement of the local police department and the presence of police 'officers at project activities may help families in some communities feel safer and thus increase program participation but, in other communities, could drrve away families uho felt uncomfortable with or suspicious of the police.

Think Big **and Start Small**

Implementing comprehensive community-based prevention programs such as the nine NCCAN projects was a complex undertaking. Developing relationships with community organizations and families required a great deal of time, patience, and persistence. The projects found that it was necessary to "think big and start small" so that goals would be manageable and staff would not be overwhelmed. Starting with one neighborhood at a time, obtaining rhe involvement of that neighborhood, discovering its unique resources and needs, and making mistakes and learning from them allowed projects to work out strategies and interventions targeted at the neighborhood and led to successful program implementation. Success in one neighborhood generated interest in other parts of the community.

The projects found that a community would find a way to continue the project's activities beyond the NCCAN grant period if the activities were built on a small enough scale to be consistent with the community's level of resources and if community institutions were involved in their development. Six of the nine projects institutionalized at least some of their activities so that the prevention efforts they began continued after NCCAN funding

Design, Implement, and Use a Strong Evaluation

The projects had major difficulties with one or more aspects of their evaluations that prevented them from persuasively demonstrating the effectiveness of their program interventions. Because NCCAN did not require process and outcome evaluations until after the projects were already well established, implementing an evaluation was problematic for some projects. This problem emphasizer; the need to develop an evaluation plan concurrently with the initial program design and to have a program evaluator working with the project at startup.

In addition. project staff, although enthusiastic about their programs, were not necessarily skilled in measurement, data collection, or analysis. This often resulted in a resistance to responding, or responding fully, to technical assistance and other research suggestions from NCCAN, CSR, Incorporated, or their local evaluators over the course of the grant period. Thus, the outcome evaluation findings are inconclusive regarding program performance. The projects did, however, provide compelling narrative and anecdotal evidence attesting to their positive effects in the communities and, in general, found that information obtained through their evaluations was useful as an ongoing project management tool. The importance of receiving feedback from the evaluation as the projects were stabilizing highlights the need to have a robust process evaluation in place from the beginning.

The results of the cross-site evaluation suggest the following themes pertaining to the evaluation design, measurement of variables, timing of the outcome evaluation, and value of the process evaluation:

- To identify measurable effects of prevention programs on child maltreatment, it is necessary to implement a sound evaluation design. This would include the use of matched comparison subjects or longitudinal designs, valid and reliable outcome measures (that are culturally appropriate and age appropriate), and statistical analysis techniques that examine interrelationships among key outcome variables.

- To understand the complex interrelationships that exist among risk factors for child maltreatment, it is important to measure intermediate variables (e.g, family relationships and social networks) as well as terminal variables (e.g., child discipline practices and CPS reports).

- To ensure that the outcome evaluation of a demonstration project has a chance to identify measurable program effects, the outcome evaluation should not be conducted until program implementation has stabilized (i.e., until delivery of program services has become consistent). Findings from this study suggest that when a project attempted to evaluate outcomes while the intervention was still unstable, evaluation findings were inconclusive. This does not mean, however. that the project should wait until stabilization to begin working with an evaluator or to develop an evaluation plan. The evaluator and the evaluation plan should be in place from the beginning.

- To monitor and improve program performance and to understand positive, negative, or no program outcome results, it is important to treat the process evaluation as an equal partner to the outcome evaluation.

- To alleviate program staffs anxiety about or resistance to evaluation, staff training must be provided and efforts made by Federal and evaluation staff to enlist staff cooperation.

These issues need to be addressed in the planning stages of program design. They should be guided by funding criteria that specify evaluation requirements while allowing for individuality in program design so that new ways to prevent child maltreatment may develop.

POLICY IMPLICATIONS

The results presented in this report do not provide unequivocal answers to the questions of what works to prevent child maltreatment and why. However, the projects' experiences in implementing their prevention programs suggest several general themes that have important implications for NCCAN program and policy development.

Program Scope

The broad scope of the original grant announcement encouraged the grantees to implement a wide range of components and target

an extensive array of families. This scope reflected findings from recent research that suggest that effective prevention requires multiple strategies to reduce family and community stressors, raise parents' understanding of developmentally appropriate behavior, improve the functioning of social networks, and improve the entire community's level of understanding about how to build and support resilient families (Advisory Board on Child Abuse and Neglect, 1993a, 1993b). 'In response to the announcement.. some grantees Incorporated a broad family support focus. This made it difficult for some projects to focus on and attain their key program objectives pertaining to enhancing community collaboration to prevent child abuse and neglect. The broad scope of the grant announcement was not feasible within some grantees' budget limitations, institutional barriers, and other priorities. and at tirnes their attempts to he responsive led to a diffusion of program efforts.

Thus, it is recommended that NCCAN focus future grant programs on fewer components or more narrowly defined target populations For example, the focus could be on one type of prevention (i.e., primary, secondary, or tertiary) or on only some types of interventions (e.g., services for parents under stress and accompanying support services). Although such an approach would not address all the risk factors that contribute to child abuse, it would focus resources to have greater impact on some of the risk factors.

In addition to a narrower focus, it is recommended that the scope of services and target populations explicitly incorporate a neighborhood-based approach. Both researchers and practitioners have emphasized the importance of the neighborhood in human service interventions (Advisory Board on Child Abuse and Neglect 1993a; Harry, 1992; Cochran, Larner, Riley, Gunnarsson, and Henderson, 1990. National Commission on Child Welfare, 1990). Prevention programs should focus on strengthening neighborhoods both physically and socially to promote the healthy development of children and families. This follows the recommendation of the Advisory Board on Child Abuse and Neglect (1993a) to incorporate a comprehensive neighborhood-based approach to achieve positive effects on community safety, mental health, education, family welfare, and possibly the local economy.

Although a narrower scope is recommended, the 5-year funding period should be retained. The projects found that the 5-year period gave them the opportunity to make changes to be responsive to the needs and characteristics of the target community; shorter grant periods allow little opportunity to adapt in response to what is learned after program implementation Demonstration projects generally exhibit a four-phase lifecycle including (1) the startup phase; (2) the growth, development, or transformational phase: (3) the stable/mature phase; and (4) the institutionalization phase.[10] Sometimes they need to go through the lifecycle more than once to be responsive to what does, and does not work in the community. If the lifecycle is cut short, a project will be unable to achieve its goals, and little will be learned from its experience. The 5-year period was long enough to enable rht: majority of the projects to complete the lifecycle, institutionalize at least some of their services within their target communities, and continue beyond the NCCAN funding.

Community Involvement

All nine projects found that to reach their target families and create genuine changes in the communities, they had to involve the communities in the planning, implementation, and operation of their projects. Using community-based advisory councils was one strategy that all nine used to achieve community involvement, although it was an optional component in the grant program announcement. They also found that it was important to reflect the unique cultural, linguistic, and social characteristics of the target communities and to find creative ways to engender a sense of

[10] For a discussion of the four phase lifecycle in community-based family support projects, see Head Start Bureau (1994)

community ownership of the projects. The importance of community involvement to these projects suggests that comprehensive, community-based projects such as these should be required to use a community task force, reflect the language and culture of the target community, and address in their grant proposals the ways that they planned to achieve community ownership of the project. Requiring new demonstration projects to incorporate community task forces into their initial program design and to think early on about achieving community involvement and ownership would save later time and effort.

Program Evaluation

The experiences of the nine projects suggest several steps that NCCAN could take that would improve the quality of prevention projects' evaluations and help the prevention field to better understand what works.

Assess Available Instruments and Develop Recommendations.-To determine the effectiveness of a class of prevention programs on child maltreatment variables, it is necessary to employ the same valid and reliable measures in each program. Based on the problems the NCCAN projects encountered with finding or developing measures of key intermediate and terminal outcomes, it is recommended that a systematic assessment of available measures of intermediate and terminal prevention intervention outcomes be undertaken. (For example, see Exhibit 2 of this report.) This effort should focus on developing recommendations of valid and reliable instruments for application in a wide variety of settings and situations (e.g., measures appropriate for different cultural groups, different languages, different ages/developmental stages, and different locations). These recommendations then should be provided to grantees.

Specify Evaluation Requirements.-Findings from this study suggest the importance of conducting research that will examine the magnitude, direction, and meaning of the relationships between identified intermediate intervention outcomes and terminal outcomes. This research also should examine whether different patterns and strengths of relationships are related to the type of prevention intervention (e.g., theoretical or experiential); mode of service delivery; and program setting. CSR recommends that NCCAN provide to grantees a research framework and priorities delineating key research questions on child maltreatment and require grantees to implement appropriate process and outcome evaluation designs to answer the questions. CSR also recommends that NCCAN thoroughly assess each potential grantee's familiarity with the theoretical underpinnings of the proposed intervention and their relationship to anticipated outcomes as well as the quality of each potential grantee's evaluation design.

CSR recommends that NCCAN provide to potential grantees specific guidelines on the various aspects of the evaluation process and require prospective grantees to fully address how they would implement these guidelines. These guidelines should include, but not be limited to, the following areas:

- The types of evaluations required (e.g., process and outcome);
- Suggested or required research designs and methodologies to be used and valid and reliable research instruments and measurement strategies relevant to the prevention of child maltreatment and
- The proportion of the budget to be committed to the evaluation effort (a minimum requirement might be 15 percent).

CSR recommends that NCCAN require prospective grantees to fully discuss in their proposals the timing and use of an outside evaluator who is not connected to the grantee agency, as well as how the potential grantee plans to work with this evaluator so that communication between program and evaluation staff will be an ongoing and effective process. In addition, it would be very useful for NCCAN to provide a clear delineation of

t he roles of any technical assistance provider and the grantee agency with regard to the evaluation.

Finally, CSR supports the requirement that demonstration grantees participate in a national cross-site evaluation. CSR's conclusions also support. NCCAN's design of this cross-site evaluation to extend a year beyond the projects' demonstration period, and CSR recommends that future cross-site evaluations be similarly designed. CSR found that conducting site visit:; after the projects' NCCAN funding had ended allowed evaluators to verify and obtain additional evidence of changes in the communities. A final round of interviews with community residents and representatives from the media, social service agencies, and government agencies provided candid reports on the projects' impacts on and legacies to their communities.

Require Rigorous Process Evaluation.—Rigorous process evaluation is needed and should be planned during the program design phase and begun at project startup. Process evaluation is important for at least two reasons. First, it can identify important variables necessary for understanding how and why prevention interventions work or how program outcomes occurred. Second, it provides t.he grantees and the Federal government with an assessment of program read mess for outcome evaluation. Demonstration prevention program development should be closely monitored and outcome evaluation, unlike process evaluation, s hould be undertaken onlv after determining that the program has reached a relatively stable state

Move the Prevention Field Forward by Balancing Rigor and Innovation.—In calling for more rigorous evaluation, the vast differences in target commun ities and the need to explore new prevention approaches must be recognized. The Federal Government must strike a balance between specifying requirements for program evaluation and allowing for the programmatic differences that are necessarv for serving various target population5 as well as ncorporating diverse and innovative preventi on strategies. However, without strong program evaluation, including both process and outcome evaluation, projects that might have made a positive difference in their communities have a difficult time proving their effectiveness. The Federal Government, as the source of funding for many prevention projects, plays a crucial role in requiring and assisting projects' evaluation efforts to produce convincing, valid. and reliable findings. Conclusive evaluation findings are critical in guiding program development and making policy decision s that incorporate effective prevent ion approaches and, ultimately, move the prevention fie ld forw ard.

BIBLIOGRAPHY

Advisory Board on Child Abuse and Neglect. Administration for Children and Families (ACF), U.S. Department of Health and Human Services (HHS). 1995. *A Nation's Shame: Fatal Child Abuse and Neglect in the United States.* Washington, DC: Advisory Board on Child Abuse and Neglect

—. 1993a. *Neighbors Helping Neighbors: A New National Strategy for the Protection of Children* Washington, DC: Advisory Board on Child Abuse and Neglect.

——. 1993b. *The Continuing Child Protection Emergency: A Challenge to the Nation.* Washington, DC: Advisory Board on Child Abuse and Neglect.

——. *199 1. Creating Caring Communities: Blueprint for an Effective Federal Policy on Child Abuse and Neglect.* Washington, DC: Advisory Board on Child Abuse and Neglect.

American Humane Association. 1994. "America's Children: How Are They Doing'?" Unpublished factsheet.

Barnes, J.B., and Shay, S. 1995. *Evaluation of Changes in the Community: A Methodology for Assessing the Impact of Dorchester CARES.* Supplement to the final report of Dorchester CARES. Boston: Judge Baker Children's Center.

Barry, F. *1992. Neighborhood Based Approach-What Is It?* Background Paper for the Advisory Board on Child Abuse and Neglect. Ithaca, NY: Family Life Development Center, Cornell University.

Bavolek, S.J. 1990. *Research and Validation Report of the Nurturing Programs: Effective Family-Based Approaches to Treating and Preventing Child Abuse and Neglect.* Eau Claire, WI: Family Development Resources, Inc.

Berkeley Planning Associates. 1977. *Evaluation of Child Abuse und Neglect Demonstration Projects, 1974–1977.* Vol. *3, Adult Client Impact.* Hyattsville, MD: National Center for Health Services Research.

Center on Child Abuse Prevention Research. 1994. *The North Lawndale Family Support Initiative Evaluation.* Chicago: National Committee to Prevent Child Abuse (NCPCA).

Chafel, J., ed. 1993. *Child Poverty and Public Policy.* Washington, DC: The Urban Institute Press

Children's Defense Fund (CDF). 1996. *The State of America's Children, Yearbook* 1996. Washington, DC: CDF.

Children's Hospital of Pittsburgh. *1995. Children's Hospital of Pittsburgh, Family Intervention Center, Section of Community Health, Child Abuse and Neglect Prevention Project. Final Narrative Progress Report 10/1/89–3/30/95.* Pittsburgh: Children's Hospital of Pittsburgh.

Cochran, M., Lamer, M., Riley, D., Gunnarsson. L., and Henderson, *C. 1990. Extending Families: The Social Networks of Parents and the Children.* Cambridge, MA: Cambridge University Press

Cohn, A.H. 1979. "Effective Treatment of' Child Abuse and Neglect." *Social Work* 24:513–19

Cook, P.S., Petersen, R.C., and Moore, D.T. 1990. *Alcohol, Tobacco, and Other Drugs May Harm the Unborn.* Rockville, MD: HHS, Office for Substance Abuse Prevention.

Crittenton Family Services. 1995. *Neighborhood Prevention Model—I CARE Project, Final Report* Columbus, OH: Crittenton Family Services.

CSR, Incorporated. 1996a. *Preventing Child Abuse and Neglect: A Case Study of Community Coalition Acting for Positive Parenting.* Washington, DC: CSR, Incorporated.

1996b *Preventing Child Abuse and Neglect: A Case Study of Community Lifelines.* Washington DC: CSR, Incorporated.

-. 1996c. *Preventing Child Abuse and Neglect. A Case Study of Dorchester CARES.* Washington, DC: CSR, Incorporated.

— 1996d. *Preventing Child Abuse and Neglect. A Case Study of Families First in Fairfax.* Washington, DC: CSR, Incorporated.

I 996e. *Preventing Child Abuse and Neglect. A Case Study of Family Care Connection,* Washington, DC: CSR, Incorporated.

1996f. *Preventing Child Abuse and Neglect. A Case Study of* I *CARE.* Washington, DC CSR, Incorporated.

1996g. *Preventing Child Abuse and Neglect: A Case Study of North Lawndale Family Support Initiative* Washington, DC: CSR, Incorporated.

1996h. *Preventing Child Abuse and Neglect: A Case Study of PARE (Physical Abuse and Neglect Reduction Effort).* Washington, DC: CSR, Incorporated.

I 996i. *Preventing Child Abuse and Neglect. A Case Study of Project Maine Families.* Washington, DC: CSR, Incorporated.

- 1996j. *Lessons Learned: The Experience of Nine Child Abuse and Neglect Prevention Programs* Washington, DC: CSR, Incorporated.

Curtis, P.A., Boyd, J.D., Liepold, M., and Petit, M. *I* 995. *Child Abuse and Neglect: A Look at the States—The CWLA Stat Book.* Washington, DC. Child Welfare League of America, Inc.

Daro, D. 1988. *Confronting Child Abuse: Research for Effective Program Design.* New York: Free Press.

DiLeonardi, 3. 1993. "Families in Poverty and Chronic Neglect of Children." *Families in Society* 74(9):557–62.

Federal Register. June 1. 19.89. Vo 54, no. 104, pp. 23565 and 23570.

Fink, A., and McCloskey, L. 1990. "Moving Child Abuse and Neglect Prevention Programs Forward Improving Program Evaluations." *Child Abuse and Neglect* 14(2): 187-206.

Garbarino, J., **and** Kostelny. K. 1992. "Child Maltreatment as a Community Problem." *Child Abuse and Neglect* 16:455–64.

Garbarino, J., Kostelny. K., and Dubrow, N. 1991. No *Place To Be a Child: Growing Up in a War Zone.* Lexington, MA: Lexington Books.

Gelles, R. 1992. "Poverty and Violence Toward Children." *American Behavioral Scientist* 35(3):258–71

Gelles, R., and Loseke, D., eds. 1993. *Current Controversies on Family Violence.* Newbury Park, CA Sage Publications.

General Accounting Office (GAO). 1992. *Child Abuse Prevention Programs Need Greater Emphasis* Washington, DC: GAO.

Gray, E., **and** Halpem, R. 1989. *Early Parenting Intervention To Prevent Child Abuse: Meta-Analysis* Final report prepared under Grant No. 90-CA-1333. Chicago: NCPCA.

Hangen, E. 1994. *D.S.S. Interagency Domestic Violence Team Pilot Project: Program Data Evaluation* Boston: Department of Social Services.

Head Start Bureau, Administration on Children, Youth and Families, ACF, HHS. 1994. *Comprehensive Child Development Program a National Family Support Demonstration.* Washington, DC: Head Starr Bureau.

Heifer, R. 1982. "A Review of the Literature on the Prevention of Child Abuse and Neglect." *Child Abuse and Neglect* 6:25 l-6 1.

Kempe, H. 1962. *The Battered Child.* Chicago: University of Chicago Press.

Lung, C.-T., and Daro, D. 1996. *Current Trends in Child Abuse Reporting and Fatalities: The Result of the 1995 Annual Fifty State* Survey. Chicago: NCPCA.

Massachusetts Committee for Children and Youth, Inc. (MCCY). 1995. *Building the 21st Century Ark: The CARES Model for Comprehensive Family Support-Final Report: Dorchester CARES.* Boston: MCCY.

McClain, P., Sacks, J., and Frohlke, R. 1993. "Estimates of Fatal Child Abuse and Neglect, United States, 1979–1988." *Pediatrics* 91:338–43.

Meddin, J., and Hansen, I. 1995. "The Services Provided During a Child Abuse and/or Neglect Case Investigation and the Barriers That Exist to Service Provision." *Child Abuse and Neglect 9:* 175–82

Meyers, M., and Bemier, J. 1987. *Preventing Child Abuse: A Resource for Policymakers and Advocates* Boston: MCCY.

Mollerstrom, W., Patchner, M., and Milner, J. 1992. "Family Functioning and Child Abuse Potential." *Journal of Clinical Psychology* 48(4): 445–52.

Moskiwitz, J.M. 1993. "Why Reports of Outcome Evaluation Are Often Biased or Uninterpretable." *Evaluation and Program Planning* 16: 1-9.

National Commission on Child Welfare. 1990. *A Commitment to Change.* Washington, DC: American Public Welfare Association.

Newberger, E., Reed, F!., Daviel, J.H., Hyde, J., and Kotelchuck, M. 1977. "Pediatric Social Illness: "Toward an Etiologir: Classification." *Pediatrics 60 I* 78–85.

Olds, D.L. 1983. "An Intervention Program for High-Risk Families." In Hoekelman, R., ed. *Minimizing High Risk Parenting.* Media., PA: Harwal Publishing Company.

Olds, D.L., and Henderson, C.R. 1989. "The Prevention of Maltreatment." In Cicchetti, D., and Carlson, V. K., eds. *Child Maltreatment: Theory and Research on the Causes and Consequences of Abuse and Neglect.* New York: Cambridge University Press.

Osofsky, J., and Fenichel, *El.,* eds. 1994. *Caring' for Injants and Toddlers in Violent Environments: Hurt Healing* and' *Hope.* Arlington, VA: Zero to Three/National Center for Clinical Infant Programs.

Pecora, P.J., Whittaker, J., and Maluccio, A.N. 1992. *The Child Welfare Challenge. Policy, Practice, and Research. New* York;: Walter de Gruy ter.

Project Maine Families. *19'95. Final Program Evaluations: Cumberland County Child Abuse and Neglect Council's "Project Maine Families" and Franklin County Children's Task Force.* Portland, ME: Cumberland County Child Abuse and Neglect Council.

Ray., M.S., and Grzelkowski, K.J. 1994. *Community Lifelines Program Evaluation Report,* Ithaca, NY: Finger Lakes Law and Social Policy Center, Inc.

Rosenberg, M., and Reppucci, N. 1985. "Primary Prevention of Child Abuse." *Journal of Consulting and Clinical Psychology 53* :576– 85.

Rosenthal, S.J. 1995. *Final Evaluation Report for the Community Coalition Acting for Positive Parenting Project.* Philadelphia." Center for Social Policy and Community Development, Temple University.

Salovitz, B., and Keys, D 1988. "Is Child Protective Service Still a Service?" *Protecting Children* 5(2):17–23.

Schetky, D. 1978. "Preschoolers' Responses to Murder of Their Mother:; by Their Fathers: A Study of Four Cases." *Bulletin of the American Academy of Psychiatry and Law* 6:45–53.

Sedlak., A.J., and Broadhurst, D.D. 1996. *Executive Summary of the Third National Incidence Study of Child Abuse and Neglect.* Washington, DC: National Center on Child Abuse and Neglect, HHS.

Straus, M.A.. and Gelles, R.F. 1990. *Physical Violence in American Families.* New Brunswick, NJ: Transaction Publishers.

Strouse, D.L. *1995. Fairfax County Model Comprehensive Community-Based Physical Child Abuse and Neglect Prevention Project, Families First in Fairfax. Third Party Evaluation Final Report* Fairfax, VA: Families First in Fairfax.

Thompson, R.A., and Wilcox, B.L. 1995. "Child Maltreatment Research." *American Psychologist* 50(9):789–93

Vázquez Ruiz, F. *1995. Final Report on the Evaluation of the Physical Abuse Reduction Effort (P.A.R.E.) Project.* Carolina, PR: Exchange Club Center for the Prevention of Child Abuse

Vondra, J. 1993. "Childhood Poverty and Child Maltreatment." In Chafel, J.A., ed. *Child Poverty and Public Policy.* Washington, DC: The Urban Institute Press.

Wolfe, D.A. 1993. "The Role of Intervention and Treatment Services in the Prevention of Child Abuse and Neglect." In U.S. Advisory Board on Child Abuse and Neglect, ACF, HHS. *Neighbors Helping Neighbors: A New National Strategy for the Protection of Children.* Washington, DC: U.S. Government Printing Office.

Wolock, I., and Horowitz, B. 1984. "Child Maltreatment as a Social Problem: The Neglect of Neglect" *American Journal of Orthopsychiatry* 54(4):530–41.

Zeanah, C.H., and Burk, G.S. 1984. "A Young Child Who Witnessed Her Mother's Murder: Therapeutic and Legal Considerations." *American Journal of Psychotherapy 38:* 132–45.

APPENDIX A

SAMPLE MEMORANDUM ON OUTCOME ASSESSMENT MEASURES

Memorandum

Date: August 30, 1993

To: Technical' Advisory Panel Members (see list below)

From: CSR, Incorporated

Subject: Relevant Outcome Assessment Measures for NCCAN Grantees

As discussed at the Technical Advisory Panel meeting on June 8. 1993, attached is a revised collection of relevant outcome assessment measures (summaries) for NCCAN *grantees.* This collection was derived from an exhaustive search of the published and unpublished literature regarding child abuse and neglect prevention, child and family development, and family support and functioning. In order to meaningfully limit the number of measures, we employed five general criteria: cultural appropriateness, relevance to the grantee interventions and objectives. technical quality, feasibility, and coverage.

Each measure was reviewed with regard to whether it measured the knowledge. attitude. or behavior domains targeted by grantee interventions. Each grantee's program plans were reviewed and a list of the domains was developed. Instruments were then identified that appeared relevant to the domains. For example, two grantees are implementing the Bavolek training Parent Nurturing Program curriculum; hence, the Adult-Adolescent Parenting Inventory was selected. Each measure was then reviewed for its technical quality-that is, its reliability and validity While there are no "magic" cutoff scores for reliability and validity estimates, we employed a general rule of acceptance above .60 for test-retest (l-3 months) and .70 for internal consistency estimates, and sufficient evidence of face, content, and construct or criterion-related validity (correlational analyses, factor analyses. etc.). While it is important to have measures that are relevant and technically sound, it is also important that they be easily obtained (at minimum cost) and administered (requiring only a minimum of training or practice). Each measure was reviewed for its cost, availability, reading level, training requirements. and ease of scoring and interpretation. *Finally,* in order to assure that we had covered each of the domains targeted by

the ... interventions, we selected at least one measure for each domain that was judged rel... technically adequate. and feasible.

In addition to the criteria described above, we have also kept our list short. By limiting the list, we will both help grantees choose from an already pared down set of selections and we will encourage them to use at least some of the same measures across sites. As the attached matrix indicates, we expect (and in several cases have already received written assurance') that these scales will be used by at least 3 or 4 sites. Clearly. the more frequently a scale is administered across sites, the more chance we will have to conduct some type of cross-site analysis.

The attached list contains the selected measures. For each measure, we provide a, brief narrative summary, as well as a, summary of' critical information regarding the purpose, author, publisher. cost, time and type of administration, reading level, and language availability. Also attached is a matrix arraying each of the grantee sites by key characteristics such as the domains targeted by the interventions, types of interventions, relevant instruments, and mode of administration. Note that in some case:, we fully expect to recommend additional instruments or sanction grantee - suggested instruments that may be uniquely relevant (for example, one grantee is interested in learning about how participants perceptions of their own cultural/racial identify has changed as a result of the program interventions -- in this case, we are providing the grantee with a list of instruments that measure such constructs as racial self-identify. pride, and bonding).

Please take a moment to review the instrument summaries and provide us with feedback regarding your experience with and/or knowledge of the measures. You may respond via either telephone or letter to Anne Baber Kennedy at (202) 842-7600/CSR, Incorporated, 1400 Eye Street, NW, Washington, DC 20005.

Adult-Adolescent Parenting Inventory

Author: Stephen J. Bavolek

Title: Adult-Adolescent Parenting Inventory (AAPI)

Purpose: The AAPI is designed to assess parenting and child-rearing strengths and weaknesses based on information taught in Stephen Bavolek's Parent Nurturing Program (PNP). The responses to the inventory provide an index of risk (high, medium, low) for practicing abusive and neglecting parenting and child rearing behavior (Bavolek 1984). The AAPI is a reasonable measure for any grantee programs implementing parent training curricula that cover some of the same constructs as the Bavolek program (parental expectations, non-corporal punishment, and parental role).

Publisher: Family Development Resources
3160 Pinebrook Road
Park City, UT 84060

Items/Scales: The instrument consists of 32 items organized into four subscales:

- Inappropriate parental expectations of the child
- Inability of the parent to be empathetically aware of the child's needs
- Strong parental disbelief in the value of punishment
- Role reversal

Price: AAPI Kit — $57.50

Reliability: Internal consistency alpha's ranged from .70 to .86 across subscales. Test-retest reliability was .76 over one week for all of the items. For each of the four separate constructs it ranged from .39 to .89.

Validity: Data indicate significant differences on subscale mean scores between abusive and non-abusive adults.

Time to Administer: 20-30 minutes

Mode of Administration: The AAPI may be administered by any professional or paraprofessional who can read and follow the instructions in the handbook. The inventory

may be administered individually or in a group setting.

Population: The AAPI is useful in assessing the parenting and child-rearing behaviors of adolescents (ages 12-19), prospective parents, parents who have completed some type of parent education, foster parent applicants, and prospective child care workers.

Reading Level: Sixth grade

Languages: English and Spanish

Child Abuse Potential Inventory

Author: Joel S. Milner

Purpose: The Child Abuse Potential (CAP) Inventory was developed for use by protective services workers as a screening tool in their investigations of reported physical child abuse cases. The CAP Inventory has also been used in numerous evaluations of program interventions and other research dealing with child abuse. Although it was originally designed to identify potentially abusive parents in at-risk populations, it has been applied in prevention research as a proxy variable for propensity to abuse (e.g., Barth, 1989; Wolfe, et al., 1988).

The CAP Inventory offers a number of advantages. It has very well-established psychometric properties, contains validity and response distortion scales, and renders several factor scale scores measuring distress (parental adjustment problems) parenting rigidity, parental unhappiness, problems with child. self. and others. ego strength. and loneliness.

Since the CAP Inventory was designed as a general screening instrument. This differentiates it from tests of knowledge acquisition or attitude change tied to particular parenting interventions (e.g., the AAPI and Bavolek's PNP). Therefore. the CAP Inventory could help facilitate some cross-site comparisons of parenting interventions which are similar but do not follow exactly the same curricula. For example. Bavolek's program tries to reduce "parent-child role reversal" and the AAPI has a scale intended to measure this construct- To the extent that they dc not emphasize role-reversal, other parenting programs may appear deficient if assessed with Bavolek's instrument. The same would be true if PNP outcomes were assessed using an instrument designed specifically for some other intervention.

Publisher: Psytec Inc.
P.O. Box 564
Dekalb. IL 60115

Scales: The six dimensions of abuse potential measured are distress, rigidity, unhappiness. problems with child and self, problems with family, and problems from others.

Price (1988): $12 for 10 inventory booklets
$18 per basic scoring template
$38 per complete scoring template
$1 per inconsistency scoring template

$1 per 10 raw score summary sheets
$28 per manual
$40 per CAPSCORE program

Reliability: KR-20 internal consistency estimates .92-.96 for controls, .95-.98 for abusers
Test-retest reliability r=.91 for 1-day and r=.75 for 3-month intervals.

Validity: In high base rate samples approximately 80% correct identification of abusers.

Time of Administration: 12-20 minutes

Items/Scales: The 160 items are organized into six dimensions of abuse potential: distress. rigidity, unhappiness, problems with child and self. problems with family, and problems with others.

Mode of Administration: Self-report, paper and pencil under the supervision of a trained non-professional.

Population: The CAP Inventory was designed for use with male and female parents or primary caregivers who are suspected of physical child abuse.

Reading Level: Third grade

Languages: English and Spanish (known only to have been used with residents of Spain)

The Child Well-Being Scales

Author: Stephen Magura and Beth Silverman Moses, Chiid Welfare League of America

Purpose: The Child Well-Being Scales measure a family's (or a child's) position based on 43 separate dimensions covering parental roie performance, familial capacities, child role performance, and child capacities. The Parental Disposition subset of the Child Well-Being Scales (Magura and Moses, 1986) could be used to describe parent functioning in related areas such as capacity for child care, interactions with children, protection from abuse, abusive physical discipline, and children's family relations. This subset is comprised of 14 of the 43 Child Well-Being Scale items. (Each "scale" consists of a single item rating particular family circumstances on a continuum of adequacy). Child Well-Being Scale ratings are given by social service workers who are familiar with the situation of the family.

The estimated time for completion of all 43 of the scales is 25 minutes. Thus. it should be possible for a worker to complete the 14 scales necessary to render the Parental Disposition score in less than 10 minutes. Internal consistency of the Parental Disposition item subset is measured at an alpha of .86. The authors of the instrument note that "the Parental Disposition and Child Well-Being Scales are close to being redundant, with 77% common variance" (p. 186). Hence, the user gains much of the utility of the whole scale with only 34 percent of the items.

The Parental Disposition measure could be used as a pre-and-post indicator of the parent functioning in sites implementing a variety of family support interventions. Both this instrument and the Parent Outcome Interview have the advantage of being free of charge to grantees.

Publisher/
How Obtained: Magura and Moses (1986) serves as the manual
Child Welfare League of America
440 First Street, N.W.
Washington, D.C. 2000 1

Scales: There are 43 separate dimensions which cover the following four areas: (1) parenting role performance, (2) familial capacities, (3) child role performance. and (4) child capacities.

Price: Free of charge for non-profit research and evaluation.

$1 per 10 raw score summary sheets

Reliability: Kappa. for inter-rater [illegible]ent on 72 families of .60.

Validity: The behaviorally-anch[illegible]le vels" of each dimension were judged as ordinal in a sample of 600 casework[illegible]s for 30 of 41 original scales.

Time of Administration: 25 minutes for completion once the social worker is familiar with the case

Number of Items: 43

Mode of Administration: This instrument was designed to be completed by a service provider, usually a social worker, based on all credible information available on a family. Some direct interaction with the family as well as home observation is required for accurate completion. Completion should be based on intake studies or other comprehensive assessments.

Population: caseworkers

Parent Outcome Interview

Authors: Stephen Magura and Beth Silverman Moses

Purpose: The Parent Outcome Interview (Magura and Moses. 1986) was designed to provide information on family problems at referral and on service deliver) through retrospective questioning. The Parent Outcome Interview obtains the client's assessment of agency services and case outcomes in child welfare cases. Parents are interviewed only once, preferably at the conclusion of service. Portions of the Parent Outcome Interview could be used to gather data from parents served by a grantee. This instrument consists of eleven self-contained sections which assess (1) the client's point of view on services received and (2) case outcome. A major point in this instrument's favor is that it was designed to capture the client's perceptions of changes in problem areas since initial contact with a service agency. The data address change over time and specifically note whether. in the parent's opinion, they were due to the particular intervention employed. Our difficulties in gathering baseiine information on program participants can thereby by partially circumvented.

Depending on the exact intervention being addressed, different sections of the interview could be used. However. the three which seem to be most pertinent to abuse and neglect prevention outcome are Section 4, Physical Child Care; Section 5, Discipline and Emotional Care of Children; and Section 10. Parental Coping. Another section which would be generally pertinent to parents who have been seeing a particular staff member would be Section 11, Relationship with Social Worker.

It is possible to quantify responses into a "change rating" for the domain covered by each section of the instrument. This rating is supplemented by open-ended queries about services received and their relationship to improvement or deterioration in the problem area. The authors estimate internal consistency of ratings across the eight problem areas at an alpha of .78.

The authors note that administration of an earlier version of the instrument consisting of I6 sections took about 2 hours per client for an average of 7.5 minutes per section. Hence, it would take about 30 minutes for the four sections of the protocol noted above to be administered. They also note that the insaument should not be administered by workers to their own clients. This restriction presumably serves to assist parents in speaking openly about negative experiences with the worker.

INSTRUMENTATION MATRIX

Grantee	Intervention	Activity	Domain	Design	Relevant Instrumentation	Sample
Children's Hospital of Pittsburgh	Parent education	Parent education classes throughout Allegheny County	Parenting skills	Pre/post	Grantee-developed form	All new parenting class participants
	Drop-in ∞ oter	Home visits Parenting training Parent support Advocacy/referrals	Parental stress Parenting skills Social support Home environment	Quasi-experimental design with com. arison group	CAP Parent Outcome Interview Child Well-Being Scales	Selected participants and a matched comparison group
Cornell University	Support services for Parents under stress	Parent Partner Program and story telling	Paren al stress	Pre/post	CAP Parent Outcome Interview	All [illegible]
Cumberland County Child Abuse and Neglect Council (CCANC)	Support services for parents under stress	Project SOAP	Pa retal stss Social support	Time-series design	Parent Outcome Interview	All current participants
		Parent center	Parental stress Social support	Time-series design	Parent Outcome Interview	All current participants
		Parent-to-Parent (first-time parenting program)	Parenting skills	Time-series design	Parent Outcome Interview	All current participants

Instrumentation Matrix *(continued)*

Grantee	Intervention	Activity	Domain	Design	Relevant Instrumentation	Sample
Exchange Club Center for the Prevention of Child Abuse (ESCAPE)	Parent education	Prenatal education in clinics via PARE-trained health department staff	Parenting skills	Pre/post	Family Strengths Scale Parent Outcome Interview Child Well-Being Scales	All new parenting class participants
	Drop-in center	Respite center for parents	Parenting skills Social support Stress	Time-series design	Parent Outcome Interview Child Well-Being Scales Spanish Family Strengths Scale	All current participants
	Home visits	Visits to homes by volunteers aides	Parenting skills Stress Home environment	Time-series design	Parent Outcome Interview Child Well-Being Scales	All current participants
Fairfax County Department of Human Development	Home visits	Hawaii Healthy Start	Parenting skills Social support Home environment	Time-series design	Parent Outcome Interview Child Well-Being Scales CAP	All current participants

Instrumentation Matrix *(continued)*

Grantee	Intervention	Activity	Domain	Design	Relevant instrumentation	Sample
Fairfax County Department of Human Development (cont.)	Pareni educaiinn	Bavoiek Parent Nurturing Program	Parenting skills	Pre/post	AAPI Spanish AAPI CAP Parent Outcome Interview Child Well-Being Scales	All new parenting class participants
Massachusetts Committee for Children and Youth, Inc.	Parent education	Bavoiek Parent Nurturing Program	Parenting skills	Pre/post	AAPI CAP	All new parenting class participants
	Drop-in center	Parent Education and Support ESL/Family Literacy Case Management Emergency Food and Clothing	Parenting skills Social support Stress Family literacy	Time-series design	Parent Outcome Interview Child Well-Being Scales CA?	All current participants

Instrumentation Matrix (continued)

Grantee	Intervention	Activity	Domain	Design	Relevant Instrumentation	Sample
Massachusetts Committee for Children and Youth, Inc. (cont.)	Home visits	Family and Child Support (FACS) Home Health Visit	Parenting skills Social support Infant health Stress	Time-series design	CAP Parent Outcome Interview Child Well-Being Scale	All current participants
National Committee for Prevention of Child Abuse	Parent education	Parent training	Parenting skills Social support Stress	Pre/post	CAP Parent Outcome Interview	All new classes
Ohio Research Institute on Child Abuse Prevention	Home visits	Parenting skills, esteem building for mothers, referrals, and advocacy	Parenting skills Social support Child development Parental stress	Time-series design	CAP Parent Outcome Interview Child Well-Being Scales	All participants (use existing project data as baseline)
Temple University Center for Social Policy and Community Development	Parenting education	Meetings with block captains	Parenting skills	Pre/post	CAP AAPI	New cohorts
	Minigrants	Various activities	Various domains	Pre/post	CAP AAPI	New grantees